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Effects of GFATM on Georgia's Health System Development

Draft

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Table of Contents

Abbreviations and Acronyms i
Executive Summary ii
Introduction 3
Epidemiological and Country Context 5
Epidemiological Situation 5
HIV/AIDS 5
Tuberculosis 6
Malaria 7
Public Financing for Focal Diseases 7
Health Service Delivery System 10
Methodology 11
Summary of Findings 15
Policy and Stakeholders Analysis 15
CCM Functionality 19
Public Procurement 20
NGO Assessment 20
Health Care Providers 24
Laboratory Assessment 28
Access to Services 30
Conclusions 32
References 34
Annexes 36

List of Tables

Table 1 Global fund in Georgia 4
Table 2 Distribution of total health expenditure by financing sources as % of THE (Current prices) 8
Table 3 Indicators of National and International Response to HIV/AIDS 15
Table 4: Types of Services provided by NGOs 20
Table 5 Scoring of NGO's participating in GFATM project implementation in Georgia 23
Table 6 Budget size (annual per project) 23
Table 7 Percentage of providers who considered provision of services UNSAFE 25
Table 8 Percentage of providers rendering services for focal diseases. 25
Table 9 Providers' satisfaction scores 26
Table 10 Providers' satisfaction scores (participants and non-participants) 27
Table 11 Lab technicians' Satisfaction (baseline vs. end-line survey) 29

List of Figures

Figure 1 Number of HIV new and Total Cases per year (2001 - 2007) 5
Figure 2 The route of HIV infection transmissions (2000 - 2007) 6
Figure 3 All registered TB cases (1995 - 2006) 6
Figure 4 Registered Malaria cases (1996 - 2005) 7
Figure 5 State budget for HIV/AIDS prevention and treatment programs in GEL in current prices (2005 -2007) 9

Figure 6 State budget for TB prevention and treatment programs in GEL in current prices (2005 -2007) 9
Figure 7 State budget for Malaria prevention programs in GEL in current prices (2005 -2007) 10

Abbreviations and Acronyms

ARV	Antiretroviral Treatment
CCM	Country Coordination Mechanism
CSW	Commercial Sex Workers
DANIDA	Danish International Development Agency
DFID	UK Department for International Development
DOTS	Direct Observation Treatment Strategy
EU	European Union
GAVI	Global Alliance for Vaccines Initiative
GDP	Gross Domestic Product
GFATM	Global Fund to Fight AIDS, TB and Malaria
GHIN	Global HIV/AIDS Initiatives Network
GHSPIC	Georgia Health and Social Projects Implementation Center
GoG	Government of Georgia
HCF	Health Care Financing
HH	Household
HIV/AIDS	Human Immunodeficiency Virus/ Acquired Immunodeficiency Syndrome
HRG	High Risk Group
IDU	Intravenous Drug User
IMF	International Monetary Fund
LFA	Local Fund Agent
LSHTM	London School of Hygiene and Tropical Medicine
M&E	Monitoring and Evaluation
MDG	Millennium Development Goals
MDR-TB	Multi Drug Resistant TB
MoLHSA	Ministry of Labor, Health and Social Affairs of Georgia
MSM	Men having Sex with Men
NCDC	National Center for Disease Control
NGO	Non Governmental Organization
NHPD	National Health Policy Document
NMCP	National Malaria Control Program
NTP	National TB Program
OOP	Out of pocket payment
PCR	Polymerase Chain Reaction
PHC	Primary Health Care
PLWHA	People leaving With HIV/AIDS
PMTCT	Prevention of Mother to Child Transmission
PR	Principal Recipient
PTF	Prevention Task Force
RBM	Roll Back Malaria
SHP	State Health programs
SM	State Minister
STI	Sexually Transmitted Infection
SWEF	System Wide Effect of Fund
TB	Tuberculosis
THE	Total Health Expenditure
UNDP	United Nations Development Program
UNGASS	United Nations General Assembly Special Session on HIV/AIDS
USAID	United States Agency for International Development
USD	United States Dollar
VCT	Voluntary counseling and testing
WB	World Bank
WHO	World Health Organization

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Executive Summary

Global health initiatives like Global Fund to fight HIV/AIDS, TB and Malaria (GFATM), Global Alliance for Vaccines Initiative (GAVI), Roll Back Malaria and Stop TB etc. are intended to support developing countries to effectively deal with specific diseases/conditions. In practice, the vertical nature of such financing is likely to have a variety of direct and indirect effects upon health care systems, both positive and negative (1). The size and the components of the grant, makes Global Fund the most significant player, at least for now. But evidence shows that experience with disbursement of GFATM grants has caused considerable frustration in recipient countries (2). In some countries, these new financing sources are providing larger sources of funding than the entire annual public health budget. Depending on how these resources are used, they have the potential to overstretch already weakened systems, or they may serve to support to the broader health care system with potentially positive effects on other health priorities as well (3).

In Georgia, our study looked at the possible system wide impact of Global Fund on Georgia's health care system. Therefore, the aim of the study was to look at the actual effects of GFATM on the policy environment, public-private interaction, human resources and access to specific services by clients. The findings are based on a base-line survey implemented in 2004 with financial support received from EU (4) and an end-line survey financially supported by Alliance for Health Policy and Systems Research (AHPSR), within the frames of research network for Global HIV/AIDS Initiative.

Based on our findings, the main impact of GFATM on Georgia's health care system during 2004-2007 seem to be the following:

- GFATM is not expected to have a negative impact on Georgia's health care system. It is certainly contributing to improving availability and access to services for focal diseases (GFATM funding improved access to specialized care for PLWHA and TB patients and services are provided free of charge including diagnostic tests and pharmaceuticals), but does not have significant impact on improving access to general health services. In Georgia, the share of GFATM in *Total Health Expenditure* is insignificant (0.6% of THE) (5) relative to countries of sub-Saharan Africa and poor countries of Central Asia.
- However, funds provided by the GFATM are significant for paying for inputs and interventions necessary for focal diseases. Increased availability of financial resources from GFATM "helped" the Government of Georgia to move public resources for focal diseases towards other Government priorities. Therefore, public expenditure for HIV/AIDS and TB has declined since GFATM's entrance. GFATM has provided significant resources for necessary investments (facility upgrades, new equipment purchases, HR training, etc) and for recurrent costs (treatment, lab diagnostics, etc.) which allowed scaling up interventions aimed at focal diseases and therefore increased resource requirements of the health care system. Thus, Georgia's dependency on increased recurrent cost financing has grown, and when GFATM financing comes to an end the country may face significant challenges in sustaining

observed achievements. Therefore, GFATM should consider new gradual phase-out strategies over a period of 10-15 years, as opposed to an immediate exit.

- Through broader participation and consultations, assured by the CCM, Georgia has developed GFATM's proposals, which are in line with the country's priorities and are helping implement policies reflected in the national strategic documents. Therefore, it is not expected that GFATM will disrupt ongoing health care reforms.
- GFATM has facilitated development of public-private partnerships. On four occasions consortiums represented by state and non-state sector were formed that received competitive funding from GFATM/PR. This was the first time, when such relations emerged in Georgia's health sector. In addition, GFATM has had a positive impact on NGO capacity development, though more needs to be done to strengthen NGOs organizationally. Limited funds available from GFATM and other donors, while contributing to NGO organizational strengthening, are not yet sufficient and future efforts are necessary to achieve a sustained impact.
- Activities funded through GFATM have helped to change the attitude of primary care providers towards provision of services to PLWHA and TB patients. Statistically significant changes were observed between the baseline and end-line surveys in the case of HIV/AIDS and Malaria; differences in the case of TB were not statistically significant. The number of providers considering provision of services to be safe to TB patients increased by 8.2% ($t=1.94$, $p=0.1403$), to HIV/AIDS patients increased by 21.7% ($t=3.69$, $p=0.0002$) and to Malaria patients by 22.2% ($t=3.78$, $p=0.0003$). In addition, 88.6% of surveyed providers, regardless their involvement in GFATM project activities and trainings, express their readiness to provide services to the above-mentioned groups.
- Finally, GFATM funded activities for HIV/AIDS have helped create social networks and a more positive environment for HIV infected people and helped them to become more open about their status.

Introduction

Global health initiatives like Global Fund to fight HIV/AIDS, TB and Malaria (GFATM), Global Alliance for Vaccines Initiative (GAVI), Roll Back Malaria and Stop TB etc. are intended to support developing countries to effectively deal with specific diseases/conditions. In practice, the vertical nature of such financing is likely to have a variety of direct and indirect effects upon health care systems that can be either positive or negative (1). The size and the components of the grant, makes Global Fund the most significant player, at least for now. But evidence shows that experience with disbursement of GFATM grants has caused considerable frustration in recipient countries (2). In some countries, the new financing sources are providing larger sources of funding than the entire annual public health budget. Depending on how these resources are used, they have potential to overstretch already weakened systems, or they may serve as a support to the broader health care system with potentially positive effects on other health priorities as well (3).

Therefore, a number of initiatives are trying to assess the system-wide effects of Global Fund. USAID, EU and other donors have supported research network for System Wide Effects of the Fund (SWEF), which aimed at supporting a number of country case studies focused on four thematic areas: a) policy environment, b) public/private mix, c) human resources and d) pharmaceuticals and commodities (6). Irish Aid, DANIDA, Alliance for Health Policy and Systems Research, Open Society Institute, USAID and DFID also supported Global HIV/AIDS Initiative (GHIN) to explore the effects of Global Health Initiatives on existing health systems in 21 countries around the world.

In response to HIV/AIDS, TB and Malaria outbreaks which have occurred in Georgia since its independence from the Soviet Union, the country has applied for GFATM funding and, for period of 2003-2007, has received significant amounts. Table 1 presents a brief overview of all GFATM grants for this period. Therefore, our study, being part of both SWEF and GHIN network, looked at the possible system wide impact of Global Fund on Georgia's health care system. The aim of the study was to look at the actual effects of GFATM on the policy environment, on public-private interaction, on human resources and on access to specific services by clients. The findings are based on a base-line survey implemented in 2004 with financial support received from EU (4) and an end-line survey financially supported by Alliance for Health Policy and Systems Research (AHPSR) within the frames of Global HIV/AIDS Initiative research network.

Table 1 Global fund in Georgia

	Round 2	*Round 3*	*Round 4*	*Round 6*		
Component	**HIV/AIDS**	**Malaria**	**TB**	**HIV/AIDS**	**Malaria**	**TB**
Total Funding request	12,125,644	806,300	5,536,965	11,385,859	3,257,100	10,923,950
Approved Maximum	12,125,644	806,300	5,536,965	6,130,724	1,587,960	9,314,136
Principal recipient	GHSPIC	GHSPIC	GHSPIC	GHSPIC	GHSPIC	GHSPIC
Grant Agreement signed	14 July 2003	29 April 2004	25 January 2005	18 September 2007	7 May 2007	22 May 2007
Grant start date	1 March 2004	1 July 2004	1 April 2005	1 January 2008	1 July 2007	1 July 2007
Total Disbursed as of February 1, 2008	9,064,074	806,300	2,549,829	2,763,821	882,530	3,773,102
Project	Strengthening existing National responses for implementation of effective HIV/AIDS prevention and control in Georgia for 2003-2007	Strengthening existing National response for implementation of effective Malaria prevention and control activities in Georgia for 2004-2006	Expansion of DOTS implementation in Georgia	Accelerating HIV/AIDS prevention, treatment, care and support Interventions in Georgia	Consolidation of the results achieved: containing further epidemic of Malaria	Bridging the gap in the management of drug-resistant TB in Georgia
Grant objectives	ü Strengthening National Programs for Safe Blood, HIV/AIDS and STI through financial and technical support; ü Training of peer educators to work with IDU's, CSW's, MSM and Youth; ü Provision of ART.	ü Strengthening capacity of the health care services; ü Community mobilization within the framework of Roll Back Malaria Initiative	ü Improvement of case detection; ü Improvement of treatment success by DOTS expansion; ü Involvement of PHC services in TB control	ü Strengthening of national surveillance system through institutionalization of second generation surveillance; ü Improving coverage of HIV prevention programs for IDU's; ü Reducing HIV prevalence among prisoners; ü Improving survival rates of people with advanced HIV infection	ü Prevent Malaria outbreak; ü Reduce Malaria morbidity; ü Reduce potential threats caused by disease.	ü Expansion and enhancement of high quality DOTS; ü Development of capacity for MDR treatment through DOTS+ strategy; ü Strengthen TB/HIV collaboration.

Source: www.theglobalfund.org

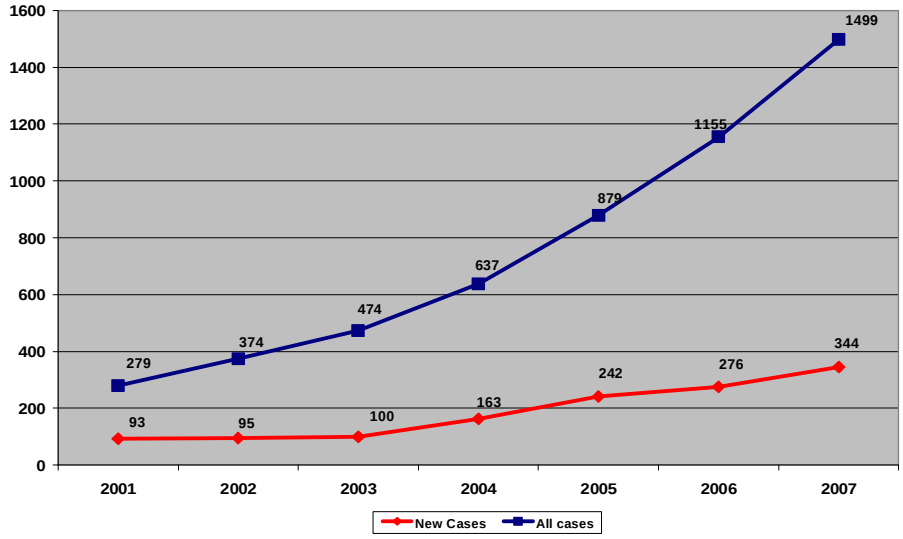
Epidemiological and Country Context

Epidemiological Situation

HIV/AIDS

Georgia is among countries with a relatively low HIV/AIDS prevalence but with the potential for developing a widespread epidemic. According to the National HIV/AIDS center as of February 2008, there were 1,534 HIV positive individuals registered in the country. In 60.4% of these cases, intravenous drug use was the mode of infection transmission, followed by 32.3% through heterosexual contact, 2.9% through homosexual contact and 2.3% related to vertical transmission. Only 0.7% of cases were due to blood transfusion. Figure 1 below presents the dynamics of HIV case registration during 2001-2007. However, official statistics does not reflect actual situation in the country. According to the national and international expert estimates the number of HIV positive cases should be around 2,800. Yet the infection transmission is mainly concentrated among intravenous drug users (IDU). According the National Institute for Drug Addiction, in 2004 there were 24,000 registered drug users, but official statistics does not reflect real situation in the country and expert estimate approximately 200,000 – 240,000 drug users in Georgia (7).

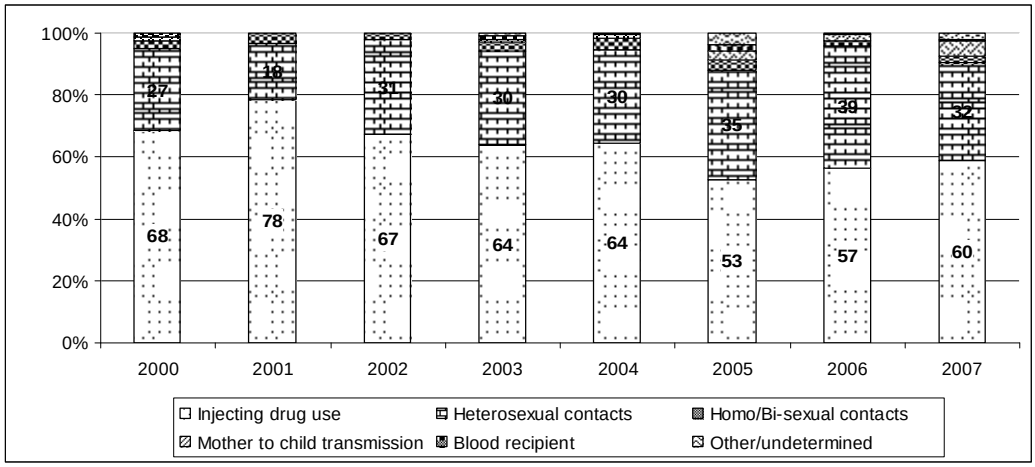
Figure 1 Number of HIV new and Total Cases per year (2001 - 2007)



Source: National HIV/AIDS Center.

The share of HIV cases caused by heterosexual transmission has been growing over the past several years while the share of new cases caused by intravenous drug use is declining. This indicates the epidemic is probably moving from IDUs into bridging population (*Commercial Sex Workers* and sexual partners of IDUs) which further increases the epidemic threat (Figure 2) and calls for immediate action from the Government.

Figure 2 The route of HIV infection transmissions (2000 - 2007)

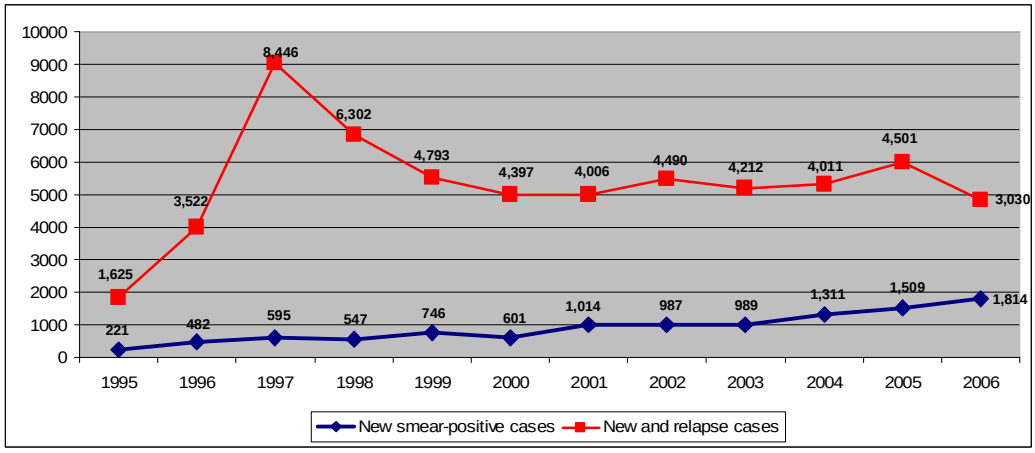


Source: National HIV/AIDS Center

Tuberculosis

Tuberculosis (TB) is recognized as one of the main public health threats for Georgia. There has been a decline in TB incidence since the 1980s. But the situation worsened in 1990s, as various factors such as the collapse of the heath care system, civil war, regional conflicts, low quality of life, growing poverty, low awareness of the society, all contributed to turning the disease into major public health challenge. TB incidence started to increase dramatically in 1990s and reached its peak in 1997. For the moment the case notification rate in Georgia is the fourth highest among former Soviet Union countries following Kazakhstan, Moldova and Kyrgyzstan. According the WHO (8) in 2006 the notification rate was 68,9 per 100,000 population (3,030 cases). See Figure 3.

Figure 3 All registered TB cases (1995 - 2006)



Source: Global Tuberculosis Control, WHO Report 2007and National Center for Disease Control and Public Health

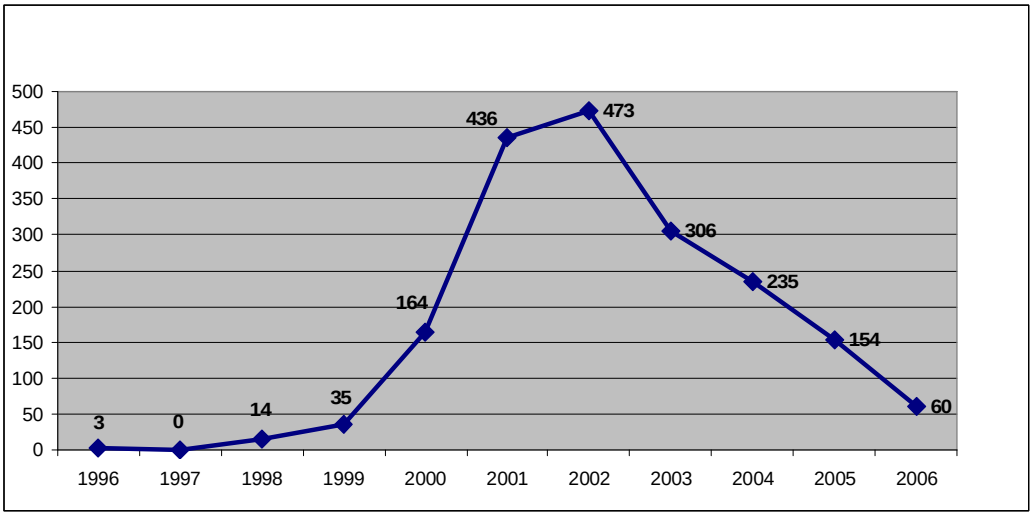
There has been progress in TB case management: treatment success rate in new smear-positive cases increased from 65.2% in 2002 cohort to 73.9% in 2004 cohort. Although

the treatment default rate remains high, it is declining since 2001 (from 24% in 2001 to 12.4% in 2004).

Malaria

Malaria has been widespread in Georgia since ancient times, as the geographical location of the country and existing climatic conditions have been favorable for malaria transmission. In the 1920's around 30% of the country population was affected by the disease, and was usually characterized by high case-fatality rates in the lowlands. Due to complex measures against malaria undertaken by the state by 1970, a complete and sustained elimination of malaria was achieved. After this eradication no indigenous transmission have occurred, but by the middle of the 1990s the risk of resurgence increased because of the gradual rise of imported malaria cases following the occurrence of large-scale malaria epidemics in bordering countries and unfavorable social and economical conditions induced by the transition period in Georgia. In 1996 the first autochthonous cases of Plasmodium vivax malaria in Georgia were registered in a settlement bordering Azerbaijan. As a result of the large-scale activities carried out by National Center for disease Control gradual decrease of the malaria incidence was achieved. In 2006 the number of recorded cases dropped to 60 (See Figure 4).

Figure 4 Registered Malaria cases (1996 - 2005)



Source: National center for disease control

Public Financing for Focal Diseases

Prior to independence in 1991, 4.5 percent of GDP was spent on health in Georgia. The estimated public health spending was around 500 USD in per capita terms. The fiscal crisis of the transition in the early 1990s hit the health sector particularly hard. Government per capita expenditure on health declined to ~US$0.8 (0.3% of GDP) in 1994 (9).

With the collapse of government revenues from 1994, private spending became a major source of health sector financing. Emergency assistance from international donors to the health sector comprised significant portion of health spending in these years and played a critical role in physical survival for many Georgians. For the moment GFATM is the main source of financing for focal diseases.

The Government of Georgia (GoG) was forced to embark on the health sector reforms along with macroeconomic stabilization measures supported by the IMF and the World Bank. In 1995 the GoG initiated major structural and financial reforms of the health sector, including deregulation, decentralization and separation of financing from the provision of services. However, continuous under funding of the health sector, inconsistency and delays in pursuing a number of important reform strategies ranging from the introduction of a single national risk pool, output based financing and selective contracting of providers, to optimization of the health infrastructure and human resources contributed to persistence of low quality and efficiency of the health system. By 2002, only 5.5 percent of all government revenues were allocated to health and total spending on health through government channels, only $5-6 per capita, or 1.1 percent of Gross Domestic Product (GDP) (10). The public health programs were financed at only 50 to 60 percent of the planned budget. The health financing burden has fallen on households who account for about three-quarters of total health spending, mostly through informal payments. This situation has changed from 2003, when the new Government elected after the "Rose Revolution" slowly but steadily increased the State funding for Health. Table 2 presents the distribution of the *Total Health Expenditure* by Sources according the National Health Accounts for 2001-2006 (5).

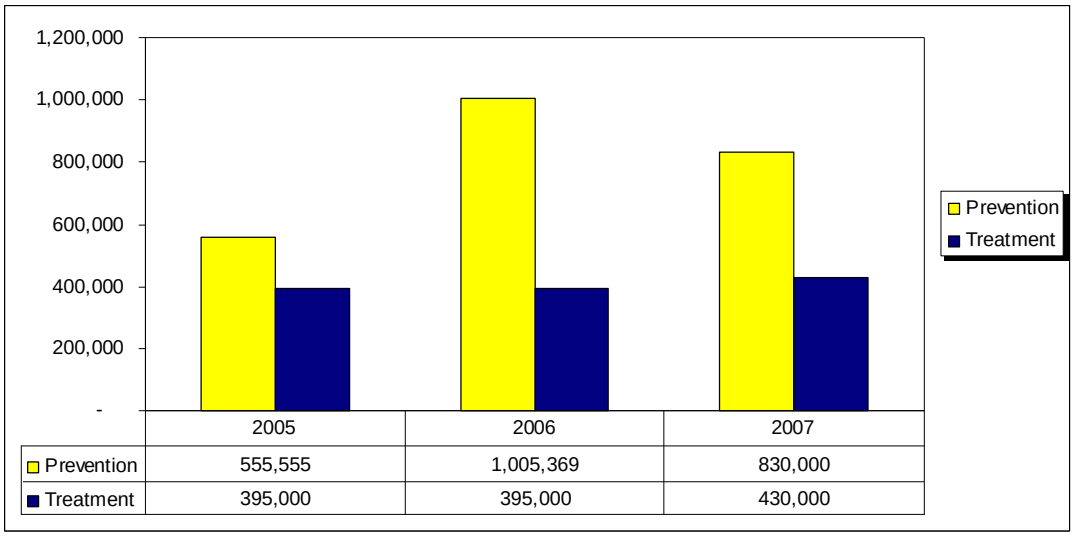
Table 2 Distribution of total health expenditure by financing sources as % of THE (Current prices)

Financing Sources	2001	2002	2003	2004	2005	2006
Total Public Funds	18%	16.4%	14.9%	15.4%	19.5%	21.6%
Total Private Funds	73.1%	71.5%	77.6%	78.4%	77.7%	73.2%
The rest of the World	8.9%	12.1%	7.4%	6.2%	2.8%	5.2%
Total Health Expenditure (Million GEL)	**521.5**	**650.7**	**724.8**	**835.9**	**998.3**	**1,160.0**
Total Health Expenditure (Million USD)	**251.67**	**296.5**	**337.8**	**436.0**	**550.7**	**653.0**
Exchange rate[1] (GEL - USD)	**2.0722**	**2.1942**	**2.1459**	**1.9170**	**1.8127**	**1.7765**

While overall state budget for health has increased, the resources allocated for focal diseases have not followed the trend. Analyses of the state budgets for HIV/AIDS, TB and Malaria programs show that despite the fact that the country has committed to increasing financing to match the GF funding, in fact financing has been decreasing (Figure 5, Figure 6, Figure 7)

[1] ***Source – National Bank of Georgia***

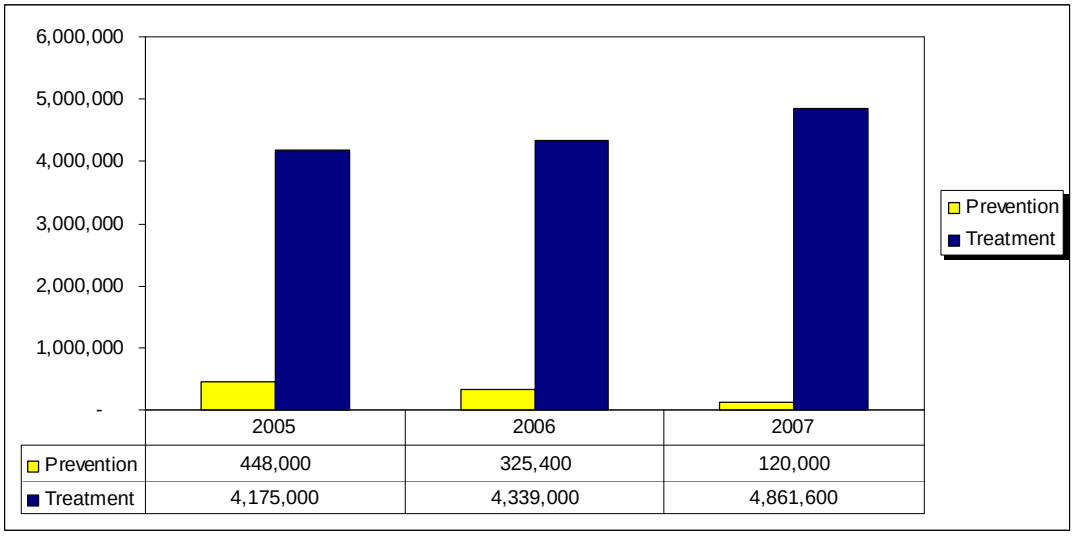
Figure 5 State budget for HIV/AIDS prevention and treatment programs in GEL in current prices (2005 -2007)



	2005	2006	2007
Prevention	555,555	1,005,369	830,000
Treatment	395,000	395,000	430,000

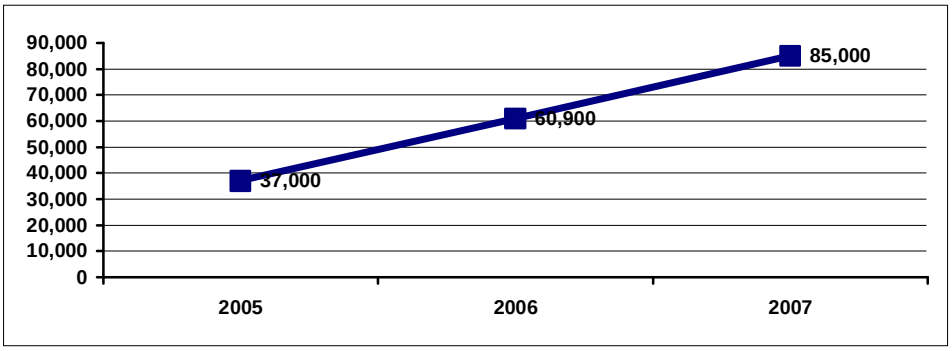
Fluctuations in prevention budgeting is common for all State funded programs (including excluding HIV/AIDS), this is historically coming from Soviet period, when the health care system was treatment oriented and very small attention was given to prevention activities.

Figure 6 State budget for TB prevention and treatment programs in GEL in current prices (2005 - 2007)



	2005	2006	2007
Prevention	448,000	325,400	120,000
Treatment	4,175,000	4,339,000	4,861,600

Figure 7 State budget for Malaria prevention programs in GEL in current prices (2005 -2007)



The figures presented aboe show that since the entrance of GFATM into Georgia, public funding for HIV/AIDS has declined and slowly increased for TB and Malaria. Most of public allocations for preventive services were reduced and replaced by GFATM. Growth in the overall public spending for health, significant during the past several years and on average increased by 23% annually (between 2001-2006), was not translated into adequate allocations for the three focal diseases. Especially for HIV/AIDS and TB, funding for Malaria has increased, but compared to the funding provided by GFATM, this increase is not sufficient.

Health Service Delivery System

Before the 1990's, health services in Georgia, as the rest of NIS countries, were organized in line with Semashko model. This system was highly centralized and mainly focused on curative services. Primary health care was a low priority and undermined both by the state and the general population. Since the start of comprehensive reforms in 1994, health care service delivery system has undergone extensive changes; more focus has been given to primary health care. Integration of services at PHC level was announced as a priority for further development and strengthening of service delivery. Despite those changes National Tuberculosis Program and HIV/AIDS remain vertical. In 2006, a new wave of reforms was announced by the Government, which came into power after "Rose Revolution" in 2003. This includes privatization of extensive hospital sector, as well as privatization of PHC. Thus for the moment it's not clear how the services for focal diseases will be delivered after the abovementioned process is finished.

Methodology

Overall research objective of the study were: to document the effects of the Global Fund-supported activities, on the health care system of Georgia, to derive lessons for Georgia, and the Global Fund itself, regarding steps to ensure that Global Fund supported activities enhance broader health care systems and contribute to priority policy objective(s).

1. Policy environment:

Specific Study Objectives:

- Will the strengthening of vertical programmes for the three focal diseases (with the help of funds from GFATM) be in line with Georgia's moves towards integration of services at primary care level?
- Will the process of GF project implementation be in line with decentralised systems in the country?

Methodology:

The study used desk research for policy analysis and in-depth interviews and structured survey tools to derive its quantitative and qualitative information. Tools were similar to those used during the baseline survey (4).

Stakeholder interviews were conducted using an instrument developed by the London School of Hygiene Tropical Medicine (LSHTM Tracking Study tool). Some additional questions were added to cover issues specific for the Georgian context (Annex 1). In total, 24 interviews were completed during the period of January 2006 – February 2007 with representatives of CCM, including Chair (16) out of those 2 were representatives of MoLHSA, 1 Parliamentary committee on Health and Social issues and 3 representatives of International NGO's, 3 representatives of local NGO's, 4 representatives of donor community, representative of National AIDS center and representative from National Institute of Drug addiction and representative of PR. Beside, interviews were conducted with staff of National Center for Disease Control, Blood Bank, 4 local NGO's who were implementing the GFATM project during the baseline, but were not contracted during the follow up survey.

For the policy analysis the research team used the AIDS Program Effort Index (API) diagnostic tool developed by UNAIDS, USAID and POLICY Project (12).

Political commitment is a concept that can not be measured easily through data not collected routinely. The purpose of the AIDS Program Effort Index is to measure the amount of effort put into national HIV/AIDS programs by local and international organizations/institutions. The API is intended to measure the effort put into HIV prevention and care. It does not measure the socioeconomic context of the epidemic and response or outcomes. API is a composite indicator composed of a number of individual items grouped into key categories. Each item is scored on a scale of 0 to 5 by knowledgeable individuals. An average of the item scores was taken for each category to produce a category score that does not depend on the number of items in the category. The category scores are the primary indicators; however an average of the category scores can produce the score for summary purposes.

2. Public-private mix:

This is an important area in Georgia where most NGOs are new and never used to carry out service delivery. There is a little prior experience of public-NGO sector partnership and collaboration. However, NGOs are proposed to be essential actors GFATM financed work for HIV/AIDS. NGO are the principal agencies to work with high-risk groups (Injected Drug Users, Commercial Sex Workers, Men having Sex with Men) who are not reached by government services. Coordination and collaboration between the MoH and other government ministries (Education, Justice, and Finance) is also a key area for success of the GFATM project, and is an area where there is little prior experience in Georgia.

Specific Study Objectives:

- How NGO are able to work with the public sector in the GFATM project – contracting methods, coordination mechanisms, etc?
- What capacity do the NGOs have to implement the project? Should the GFATM invest in NGO capacity building?
- How will the MoH communicate and coordinate with the other government ministries involved in the GFATM project?

Methodology

An assessment of organizational capacity of local NGOs implementing Global Fund to fight AIDS, TB and Malaria (GFATM) program in Georgia (HIV/AIDS component) was conducted by the CIF as part of the research on system-wide effects of the Global Fund (GF). The assessment was performed (i) through structured interviews with organizations' senior managers and (ii) on-site review of selected supportive documentation. Already utilized tool in the baseline study was used in the follow-up round (Annex 2). Total of ten NGOs (see table below) were assessed and, respectively, ten interviews with managers were performed. NGO's were selected based on existing contracts on implementation of particular activities, thus some of the NGO's who were part of baseline survey were not assessed.

To assess changes in organization capacity of NGOs, the research team used the baseline assessment to select certain organizational characteristics that were considered during the end-line survey. These characteristics included: efficiency and transparency of organizational decision making, planning and implementing program activities; geographical and financial scope and size of NGO operations; diversification of financing sources; changes in human resources (number and technical capacity), experience in forming NGO/NGO, NGO/Private and NGO/Public partnerships; audit and performance assessment systems. The relative values assigned to each characteristic then were summed up to get a comparative total value for overall organizational capacity of the assessed NGOs. A comparative total value of 18 (the sum of medium positive values for each characteristic) was considered to correspond to satisfactory organizational capacity.

3. Human resources

Specific Study Objectives

Critical issues are staff motivation, knowledge, practice and attitudes towards high-risk groups (HRG) as clients. There is no shortage of human resources in the health sector of Georgia and the issue of staff being overstretched by training commitments does not arise.

Methodology:
For the primary health care provider's survey, a modified MEASURE SPA providers survey tool was used (Annex 5). 201 primary health care providers were interviewed in 35 facilities. All relevant urban PHC facilities - rayon/city polyclinics and so called Polyclinic Ambulatory Units (PAUs) - existing and licensed to provide primary health services in selected 3 regions of Georgia were assessed with the provider survey (the same 35 PHC facilities that were sampled for the baseline survey). The names and location of the facilities were derived from the list of licensed facilities (all types) provided by National Centre for Disease Control and Medical Statistics (2005 year).

A random selection of providers (medical doctors) from the list of employees at the facility level was carried out. All service providers were selected in facilities with 6 or fewer providers and 7 or 8 providers (depending on the first random starting point in the list of employees) were selected in larger facilities.

Additionally, 25 lab technicians were interviewed in seven laboratories. During the baseline, 3 central (national) laboratories (*Central Lab of AIDS & Clinical Immunology Research Center, Lab of the National Center for Diseases Control and Lab of the Institute of Dermatology and Venerology*) and 4 regional laboratories (*Central Lab of Kutaisi Clinical Hospital, Lab of Zugdidi Clinical Hospital, Poti and Batumi Regional Public Health Centers' Laboratories*) were assessed. These laboratories were selected as they *were most likely to be targeted by the GFATM* project as facilities on central level and are in the regions with the highest prevalence of HIV/AIDS and TB. All those facilities are providing services for non-focal diseases as well. The same laboratories (except one) as in the baseline survey were assessed during the end-line survey in order to track the changes before and after GF program initiation (the *Lab of the National Scientific/Research Institute of Dermatology and Venereal Diseases was* replaced by *Batumi Blood Transfusion Station* after the list of GF targeted facilities was created*).*

The provider satisfaction questionnaire (11) was completed by providers and lab technicians in the end-line survey. Based on the tool, providers' satisfaction was rated for different components e.g. a) motivation for working; b) remuneration; c) efficiency; d) stock; e) responsibilities; and f) general satisfaction. Provider satisfaction was assessed on a five-point Likhart scale, where the score of three means neutral attitude, score below three represents negative attitude and above three positive.

Further details concerning methodology are available in Georgian language reports.

4. Access to services for HIV/AIDS HRG and PLWHA, and for TB patients

This is a crosscutting theme, which is considered to be a critical issue in Georgia's health care system where all the HIV/AIDS and TB patients are stigmatised by society, and also by health workers. The stigma posed by the general population and in certain cases by non- specialized (including PHC) medical providers limits patients access to needed services and care

Exit interviews (Annex 3) with a small sample of TB (n=19) and AIDS (n=20) patients were conducted; the tool was developed by CIF's research team.

The in-depth interview guide (Annex 4) was developed by the CIF research team together with NGO representatives working with targeted high risk groups (Intravenous Drug Users (IDU's) and Commercial Sex Workers (CSW's). In total, 60 IDU's and 60 CSW's were interviewed.

Summary of Findings

Policy and Stakeholders Analysis

Among the former Soviet Republics, Georgia was one of the first to respond to the HIV/AIDS epidemics in the early 1990's. The law on "HIV/AIDS prevention" was adopted in March 1995 and amended in March 2000. A set of strategic documents followed the laws, and research team reviewed all of them to evaluate existing policies (the list of reviewed documents is provided in Annex 6 and Annex 7).

The extensive list of reviewed documents shows, that the Georgian Government understands the importance of the problem and prioritizes the issues related to HIV/AIDS. For the policy analysis the research team used the AIDS Program Effort Index (API) diagnostic tool developed by UNAIDS, USAID and POLICY Project (12).

One of the purposes of API is to measure change. Therefore, the CIF team used the opportunity to make this comparison. Thus the information presented in table is mainly based on an expert assessment of the situation.

Similar tools were used during base-line and follow-up and the results are presented in Table 3. The findings of the table allow concluding that Georgia has organized a reasonable effort and achieved slight improvement of a policy environment when base-line and end-line data are compared. However, there is considerable room for further improvements. Namely, achievements are obvious in policy formulation process, but there is limited progress in actual implementation of these policies.

Table 3 Indicators of National and International Response to HIV/AIDS

	INDICATORS	STATUS 2004	STATUS 2007
PROGRAM RESOURCES	Resources are allocated according to priorities	+	+
	Resource allocation decision are based on considerations of cost-effectiveness of interventions	+/-[2]	+
	Adequate funding is available for public prevention programs	-	-
	Adequate funding is available for care of people living with HIV/AIDS	-	+/-
	Adequate funding is available for programs to mitigate the impact of AIDS	-	+/-
	The private sector plays a significant role in funding HIV/AIDS prevention and care programs	-	-
	International Donors have provided a significant portion of funding for prevention programs	+	+
	International Donors have provided a significant portion of funding for care programs	-	+
SUMMARY OF PROGRAM RESOURCES		-	+/-[3]
M/E & RESE	Operational and financial plans are developed that correspond to objectives and targets	+/-	+

[2] Shaded boxes shows the sections were changes has occurred
[3] Summary scores were calculated based on number of "-" and "+" in each of the sections

	INDICATORS	STATUS 2004	STATUS 2007
	Evaluation and research results are actively employed in policy formulation and program planning	+/-	+/-
	Mechanisms and structures for monitoring and evaluation, such as a formal evaluation unit, exist within the programs	-	+/-
	Special studies are undertaken as needed to improve the program	+/-	+/-
	A sentinel surveillance system for HIV infection exists and functions regularly	+/-	+/-
	A behavioral surveillance system exists and functions regularly	-	+/-
SUMMARY OF EVALUATION, MONITORING AND RESEARCH		+/-	+/-
LEGAL AND REGULATORY	Condom advertising is allowed	+	+
	There is no restriction on the import of condoms	+	+
	There are no restrictions on the condom distribution	+/-	+/-
	There are no restrictions on who may receive STI services	+	+
	There are no restrictions to the IDU treatment and prevention	-	+/-
	CSW is legalized and well regulated	-	-
	International conferences, documents, guidelines, covenants, conventions and treaties have been incorporates into national law or contributed to legal and regulatory reform	+/-	+
SUMMARY LEGAL AND REGULATORY ENVIRONMENT		+/-	+
PREVENTION PROGRAMS	Guidelines to reduce the risk of HIV transmission to health workers	+	+
	An active program to promote accurate HIV/AIDS reporting by the media	-	-
	A functioning logistics system for drugs for the treatment of STDs and opportunistic infections	-	+/-
	A functioning logistical system for condoms	-	-
	A social marketing program of condoms	+	+/-
	Special prevention programs for high-risk groups	+/-	+/-
	Confidential counseling and testing services	+	+
	Family life education for Youth	+/-	+/-
	Programs to prevent mother-to child transmission by providing testing, counseling, antiretroviral treatment and infant feeding	-	+
	National IEC program	+/-	+/-
	A harm reduction program for IDUs	+/-	+/-
	People living with HIV/AIDS are formally included in the program	+/-	+
	International research has contributed significantly to the training of local staff working in prevention programs	+/-	+/-
	International research has contributed significantly to the design of program interventions	+/-	+/-
	International Organizations have helped program design and implementation through technical assistance and guidelines	+/-	+/-
SUMMARY PREVENTION PROGRAMS		+/-	+/-

CARE PROGRAMS	Up-to-date policies exist for the care and support of people living with HIV/AIDS	-	+
	An essential package of care and support is provided through the national health system (voluntary counseling and testing for HIV, psychosocial support, palliative care, treatment for pneumonia, oral and vaginal candidiasis, and pulmonary TB, and regulated delivery of care in particular of TB, STDs and advanced care options	-/+	+
	An intermediate package of care and support is provided through the national system (essential package plus enhanced TB management, cotrimoxazole prophylaxis, systemic antifungal, treatment of Kaposi's sarcoma with essential drugs and treatment of cervical cancer with surgery	-/+	-/+
	A comprehensive package of care support is provided through the national health system. (intermediate package plus antiretroviral therapy, diagnosis and treatment of MAC, CMV, MDR TB, toxoplasmosis and HIV-associated malignancies	-	-
	A comprehensive program exists to provide needed support to AIDS orphans	-	-
	International programs have contributed significantly to the training of local staff working in care programs	+/-	+
	International research has significantly contributed to the design of care programs	-	-
	International organizations have significantly helped program design and implementation through technical assistance and guidelines	-/+	+/-
SUMMARY CARE PROGRAMS		-	+/-
SERVICE AVAILABILITY	Percent of sexually active adults in the capital city having reasonably convenient access to the following services (condoms, STDs treatment, voluntary counseling and testing, IEC programs for HIV prevention)	+/-	+
	Percent of blood transfusions using screened blood	+/-	+/-
	Percent of IDUs have reasonably convenient access to needle exchange program	-	-
	Percent of HIV+ people having reasonable convenient access to quality medical care of HIV related problems	-/+	+
	Percent of HIV+ people having reasonable convenient access to family and personal support to cope with affects of HIV	-	+/-
	Percent of youth having reasonably convenient access to the information about safe sexual practices	-/+	+/-
	Percent of pregnant women having reasonable convenient access to programs to prevent mother-to child transmission of HIV	-	+
SUMMARY SERVICE AVAILABILITY		-	+/-

Source: System wide effect Global Fund on Georgia's Health care Systems, October 2004. Curatio International Foundation

+ positive; - negative; +/- moderate

Overall, it can be concluded that there was a positive shift from 2004 to 2007. It is difficult to attribute this solely to GFATM project, but the fact is that GF is the biggest financial source for HIV related activities in Georgia. In close collaboration with USAID-funded SHIP[4] project, UNICEF and UNAIDS focal point, GFATM is the main driver in mobilizing national response to HIV/AIDS epidemic in Georgia.

In addition to aforementioned analysis, all GFATM proposals submitted by Georgia were evaluated against the state policies and reform strategies for the health sector. Our analysis showed that all these proposals were in line with the national strategic

[4] STI/HIV Prevention Project

documents. Thus, proposal development process has not affected negatively reform processes and national policy priorities.

GFATM possible impact on Health systems

Research team interviewed stakeholders to solicit their opinion whether or not the GFATM financed project will have any impact on the Georgian healthcare system?

All stakeholders concur that funds provided by GFATM can not have a major impact on Georgia's healthcare system, since the total GFATM budget for all three components during 2006 was only 2.8% of the public spending on health (5).

One of the policy makers replied:

"*Since the GFATM pays less attention to the internal structure of the programs for focal diseases that are vertically organized, the countries have to identify the priorities for these programs by themselves. As aforementioned programs are vertical, their implementation will have a negative influence on the healthcare system because, neither in the process of proposal development, nor during the implementation the need for integration of vertical programs was taken into consideration*"…

Although the majority of the interviewed **stakeholders agree on the lack of integration** of the GFATM funded programs, all of them concur that GFATM funding has a positive impact on improving service delivery and response to HIV/AIDS, TB and Malaria epidemic. The success in HIV/AIDS component is considered to be 100% coverage of all HIV/AIDS patients with ART. Nevertheless, stakeholders emphasized that detection rate of HIV cases remains very low and needs to be further improved. Moreover, all stakeholders mentioned that GFATM helped the country to further develop infrastructure (rehabilitated treatment centers, equipped labs, trained staff etc.) that could potentially help strengthen the health care system of the nation.

Major concerns expressed by almost all stakeholders are **related to sustainability** issues after GFATM funding ends.

"*After GFATM funding ends, the State budget should replace it, but evidence proves this is not going to happen. Funds allocated for the Methadone Substitution Program and Antiretroviral Treatment (ART) within the GFATM program is absolutely unrealistic to be covered by the State in the nearest future and even difficult to say when it might be possible*"…

"*We have to think about sustainability. Since GFATM funding is still available for the country, the Government tries to fill in other gaps and is not thinking what might happen after GFATM project ends "*…

Monitoring & Evaluation

Monitoring & Evaluation was identified as a weakest point in GFATM project implementation by almost all respondents. Georgia has committed to the "Three ones Strategy", however a national *Monitoring and Evaluation* system is yet still missing and does not allow adequate evaluation of effectiveness of the national response to these three focal diseases.

Furthermore, most respondents agree that GFATM project-specific M&E is quite weak, inflexible and uncoordinated. The PR is responsible for conducting M&E activities (programmatic and financial implementation) and independent financial monitoring is carried out by the *Local Fund Agent* -KPMG. Both entities are

responsible to report to the CCM. But in fact, CCM only gets reports from PR and has never received feedback or information from LFA. Respondents mentioned that the M&E approach used by the GFATM is oriented specifically on money disbursement and resource mobilization. As for indicators of quality of services, they are not addressed at all.

It was underlined, that country itself should take responsibility to strengthen and improve the M&E system and keep track of impacts that the GFATM program may have on Georgia's healthcare system. It was also mentioned, that the M&E capacity in general is very weak in the country, therefore technical support is needed. Since the GFATM program is the biggest one implemented in the country, improvement of M&E system should start within it; it is expected that this will be the case during the coming years.

CCM Functionality

Before establishment of CCM in 2003, as a condition for the grant approval, there was The Governmental Commission on HIV/AIDS and Socially Dangerous Diseases (The Commission) that had been functioning in Georgia since 1996. The commission was created to strengthen cooperation and coordination among different public agencies. The commission was comprised of senior level authorities (ministers and deputy ministers) of different ministries and state authorities. The Minister of Labor, Health and Social Affairs chaired the commission. The commission determined the national policy and strategy on HIV/AIDS prevention in the country. According to the charter, the commission was also responsible for recommending and determining the overall financial allocations for control of HIV/AIDS, monitor resource mobilization, disbursement and utilization of additional financial allocations. This Commission became the basis for CCM.

Initially the CCM had a wider representation (there were 46 members in total). At present, the number of CCM members has been decreased from 46 to 30, as GFATM secretariat considered existing one was not effective enough (as mentioned by one of CCM members). Several ministries were represented by more than one representative (e. g. MoLHSA was represented by several deputies, minister and heads of departments, for the moment minister and his designated one deputy are members of CCM). Thus GFATM advised to decrease the number of representatives, but increase the sectoral representation (e.g. representatives from the private sector, religious organizations and the education system were absent). Nevertheless, some of the respondents consider that the size of the CCM is still big. As one of NGO representatives on current CCM noticed: "Even now, there are too many members and technical details cannot be discussed".

As for the NGO sector, at present its representation is based on rotation principle. NGO community is electing their representative annually. Besides, 2 NGOs - "Georgian Plus Group" and "HIV/AIDS Support Foundation" - are permanent members of the CCM. Besides making CCM more functional, the idea with rotation was appealed to avoid the conflict of interest. There is a limited number of capable NGO's in Georgia, and so the majority of them, besides being the CCM members, were project implementers as well. A 'rotation principle' has not solved this problem totally, but has reduced the number of implementing NGO's represented at CCM. Those that remain as members do not have right to vote when a performance evaluation is done. But despite this, they still have much more information regarding the proposal development process, as well as other issues in relation with project implementation, than the NGO's which are not and were not CCM members.

During the baseline survey, most CCM members complained about the time limitations for proposal development. But, three years later, the end-line survey detected that none of CCM members mentioned that they had not seen the proposal before signing the official version. All of them were well informed about the proposal content. All of them mentioned that the appointment of First Lady of Georgia Mrs. Roelofs "*plays a positive role*" in CCM functionality, it improved attendance of CCM meetings, helped improve coordination between different Ministries and her authority also helps to solve the problems quicker. However, this appointment did not help to improve coordination between donors, which remains to be a problem.

Public Procurement

During the baseline study, a number of respondents expressed hope, that GFATM project will help simplify Georgia's State Procurement Law. However, even during the end-line survey the procedures remain pretty complicated and nothing has changed/improved with the exception that implementing agencies have become more used to these regulations.

NGO Assessment

There is a limited number of capable NGOs working in the health sector in Georgia. Until now, there are not any NGOs working in TB and Malaria in the country. Thus, it was interesting to look at capacity and organizational strengths/weaknesses of the ones who are participating in GFATM project implementation. Beside, it was interesting to see if GFATM is contributing to further strengthening of NGOs. Thus an assessment of organizational capacity of local NGOs involved in GFATM program implementation was conducted by the research team as a part of the research on effects of the Global Fund (GFATM). A List of the organizations enrolled in the survey is presented in

Annex 8.

Public-private partnerships were of particular interest for the research team. This was the first time when such partnerships were formed in Georgia's health sector and is assumed to be one of the positive effects of GFATM in the country. Six PPPs were formed for the tenders: in 2 state institutions were primary contractors and NGO's subs and in other 4 cases NGO's were prime contractors and state institutions contracted. Details about the PPP composition are presented in Annex 9. These relations hopefully will be sustainable in the future and will contribute to further collaboration between governmental and non-governmental sectors.

The type of services provided by NGO's currently implementing GF project and assessed during the survey is listed in Table 4 below. It has to be mentioned that NGOs in Georgia are not providing curative services for HIV/AIDS, as they are not licensed to provide this kind of service.

Table 4: Types of Services provided by NGOs

Name of the organization	Type Services provided by NGOs
1. Center for Information and Counseling on Reproductive Health "Tanadgoma"	• Medical and psychological counseling on different Health Care problems, including Reproductive Health problems • Promoting Human Rights, Patients' Rights, Reproductive Rights and Gender issues. • Exploring high-risk groups and socially unprotected layers of the population • Providing medical and psychological support to socially unprotected layers of the population • Assistance in referring population to appropriate medical facilities • Collaborating with mass media, focusing on Health Care and psychological problems in order to spread information, make advocacy, and shape public opinion • Conducting scientific research, conferences, training and seminars on different medical and psychological issues • Primary screening on STI/HIV/Hepatitis B/C through a mobile laboratory.
2. The Union of Victims of the Conflict in Abkhazia "Tanadgoma"	HIV/AIDS prevention in youth and IDUs Protection of equal rights of the victims Providing information and consultation services to the population;
3. "Children's Federation"	• Organizing and arrange free time for children and adolescents • Carrying out assisting programs for children and Youth; • Involving children in scientific/educational/healthy activities • Working with disabled, street and IDP children • Promotion of healthy life style
4. International Youth Network for Peace and Cooperation "Juvenco"	• Organizing and establishing charity events • Creating a youth world forum • Holding sports competitions • Organizing and conducting trainings • Holding conference for promotion healthy lifestyles among youth
5. HIV/AIDS patients support Foundation	• Prevention of HIV/AIDS and other STDs • Promotion of safe sex • IEC campaigns (TV, radio, leaflets) • Providing home care for HIV/AIDS patients • Organizing regular meetings for HIV/AIDS infected people • Conducting sociological pre-post surveys to determine effectiveness of conducted activities
6. Psycho-Social Information and Counseling Centre "Akhali Gza"	• Working with IDUs • Prevention of STDs (HIV/AIDS, Viral Hepatitis etc) • Voluntary counseling and testing (in prisons) • Psychological support of drug users and their relatives; • Conducting Seminars and Trainings
7. The Centre for Medical, Socio-Economic and Cultural issues "Uranti"	• Treatment of the Addicted (in-patient and out-patient care) • Methadone substitution therapy • Psycho-social and medical rehabilitation • Laboratory testing and counseling on HIV/AIDS, syphilis and virus hepatitis • Addiction counseling (drug-dependency)
8. "Central Institute for Retraining Teachers and Attestation"	• Retraining of Teachers • Post-graduate education • Promoting healthy lifestyle

9. "Georgian Association of Obstetricians and Gynecologists"	• Working on Reproductive Health issues • Providing all services in the field of reproductive health • Providing trainings
10. "Open Society - Georgia Foundation" – OSGF	OSGF works in 6 main directions, namely the foundation currently implements following programs: • Law program; • Mass Media Communication program; • Public health program; • Women's Program; • Social Science Supporting Program; • NGO Support Program.

A question of particular interest was whether the GFATM has contributed to organizational capacity strengthening of the participating NGOs. Six out of ten assessed organizations consider that GFATM program supports and contributes to their development through a) providing professional trainings to their staff members (attending international conferences, international trainings etc.); b) providing material resources to the organization and c) attracting additional staff. The survey showed that after initiation of GFATM program total number of staff has increased in eight out of ten assessed organizations; the number of permanent staff members in almost all assessed NGOs is limited to the administrative staff (directors, accountants, office managers etc.). As for professional/program staff, they are contracted within the projects and their number depends on the size and number of implemented projects. It was also mentioned that the trainings offered by GFATM are mainly for technical personnel and little is offered for managerial and administrative staff, which limits institutional development of the organizations.

Furthermore, the operational setup of GFATM, wherein PR issues very detailed specifications for the tender and after contracting, micromanages the implementing partners, further limits organizational development of NGOs.

To assess changes in organization capacity of NGOs, the research team used the baseline assessment to select certain organizational characteristics that were considered during the end-line survey. These characteristics included: efficiency and transparency of organizational decision making, planning and implementing program activities; geographical and financial scope and size of NGO operations; diversification of financing sources; changes in human resources (number and technical capacity), experience in forming NGO/NGO, NGO/Private and NGO/Public partnerships; audit and performance assessment systems. Five out of ten NGOs studied during the end-line survey were not active in GFATM projects at the time of the baseline survey. Therefore, our conclusions are only based on these five NGOs, which showed that their capacity has improved slightly (details are presented in Table 5). The following characteristics were selected for these purposes:

- Well functioning supervisory board,
- Existence of formal organizational policy/manual;
- Existence of regional branches in different regions of Georgia;
- Number of implemented projects;
- Existence and level of formal staff evaluation systems;
- Existence and level of long term planning ;
- Degree of diversification of funding sources
- Existence and level of financial reporting/external audit arrangements

- Existence of formal partnerships;
- Existence and level of performance assessment tools.

The relative values assigned to each characteristic then were summed up to get a comparative total value for overall organizational capacity of the assessed NGOs. A comparative total value of 18 (the sum of medium positive values for each characteristic) was considered to correspond to satisfactory organizational capacity.

Table 5 Scoring of NGO's participating in GFATM project implementation in Georgia

Name of the NGO/organization	End-line Score	Baseline Score
"The Union of Victims of the conflict in Abkhazia "TANADGOMA"	**7**	-
"AXALI GZA"	**16**	-
"Children's' Federation"	**23**	**19**
"Central Institute for Retraining of Teachers and Attestation"	**19**	**17**
"Georgian Association of Obstetricians and Gynecologists"	**14**	**12**
Union "URANTI"	**8**	-
"Open Society - Georgia Foundation" (OSGF)	**31**	**27**
"Tanadgoma"	**18**	**16**
Union "Juvenko"	**15**	-
HIV/AIDS support Foundation	**11**	-

The Research team also looked at the financial implications of GFATM on the NGO sector development. Table 6 presents the results of this assessment and shows that the size of GFATM projects exceeds the maximum budgets for other implemented projects by NGOs. All studied organizations, with exception of OSGF, refused to reveal their annual budgets, thus research team was not able to compare share of GFATM funding in NGOs' annual revenue.

Table 6 Budget size (annual per project)

NAME OF THE ORGANIZATION	Min budget of non-GF projects (in USD)	Max budget of non-GF projects (in USD)	GFATM program budget (in USD)
1. Center for Information and Counseling on Reproductive Health "Tanadgoma"	Information not available	Information not available	• 105, 295 USD (2006-2007)
2. The Union of Victims of the Conflict in Abkhazia "Tanadgoma"	5,112 USD (2006)	52,000 USD (2006)	• 47,800 USD (2004-2005) • 14,000 USD (2005-2006)
3. "Children's Federation"	1,700 USD (2006)	476,363 USD (2006)	• 210,700 USD (2004-2005) • 160,000 USD (2005-2006) • 336,610 USD (2006-2007)
4. International Youth Network for Peace and Cooperation "Juvenco"	1,000 USD (2006)	22,400 USD (2006)	• 13,500 USD (2004-2005) • 15,200 USD (2005-2006) • 44, 900 USD (2006-2007)
5. HIV/AIDS patients support Foundation	Information not available	Information not available	• 58,823 USD (2006-2007)
6. Psycho-Social Information and Counseling Centre "Akhali Gza"	800 USD (2006)	25,000 USD (2006)	• 57,772 USD (2005-2006) • 60,671 USD (2006-2007)
7. The Centre for Medical, Socio-Economic and Cultural issues	9,500 USD (2006)	17, 540 USD (2006)	• Exact information was not provided, however it was

"Uranti"			mentioned that GFATM program has the biggest budget
8. "Central Institute for Retraining Teachers and Attestation"	Information not available	Information not available	• 6,300 USD (2006-2007)
9. "Georgian Association of Obstetricians and Gynecologists"	Information not available	Information not available	• 42,255 USD (2006-2007)
10. "Open Society - Georgia Foundation" - OSGF	4,508,110 USD (Annual budget for Public health program in 2005)		• Information not available

While it is obvious that GFATM has had positive impact on NGO development, respondents pointed to the following needs, which they still face:

- Ø Additional financial support from donors and from government/state sector
- Ø Improving staff motivation and development the staff evaluation system
- Ø Increasing availability of trainings, especially in project and organization management issues.

It can be concluded that NGOs need further organizational development and this has to be taken into consideration by donors, including GFATM.

Health Care Providers

Unlike African countries, a shortage of health care providers is not an issue in Georgia. Critical issues are staff motivation, knowledge, practice and attitude towards representatives of high risk groups, as well as HIV/AIDS and TB patients as clients.

The baseline survey found an alarming share (from 40 to 50%) of primary care doctors who had the perception that it is unsafe to provide care to patients with focal diseases. The baseline showed that a hidden stigma existed among providers and thus it was decided to evaluate the impact of GFATM on primary care providers and on their perceptions. Compared to the baseline, the end-line survey revealed that the number of providers considering care for a person with HIV/AIDS, TB and Malaria is safe has increased significantly. During the baseline, the percentage of those who considered providing care to TB patients as unsafe was 61%, which has decreased by 8.8%, as end line survey revealed. Percentage of those who considered provision of services for HIV/AIDS has decreased by 21.7%. During the baseline survey 61.0% of providers mentioned that providing care to Malaria patients is unsafe, however during the end-line survey their number has been decreased by 22.2% (38.8%).

Table 7 Percentage of providers who considered provision of services UNSAFE

	Baseline (% of providers who responded negatively) N=105	**End-line (% of providers who responded negatively) N=201**	**T-value**	**P-value**
In your opinion, is it safe to provide care to TB patients?	61.0%	52.2%	1.49	0.1403
In your opinion, is it safe to provide care to AIDS patients?	61.0%	39.3%	3.69	0.0002
In your opinion, is it safe to provide care to Malaria patients?	61.0%	38.8%	3.78	0.0003

Furthermore, the number of primary care providers rendering services to AIDS, TB and Malaria patients has increased in the study regions when compared to the baseline.

Table 8 Percentage of providers rendering services for focal diseases.

	Baseline N=105	**End-line N=201**
Are you providing care to TB patients?	21.0%	42.3%
Are you providing care to AIDS patients?	2.9%	29.9%
Are you providing care to Malaria patients?	12.4%	31.3%

Among those who refuse to offer services to the patients with focal diseases, the main reasons for the refusal were lack of necessary qualifications in 95% of cases and only 5% said they have no desire to do so. These, in addition to findings from the *High Risk Group* and patient survey, show that hidden stigma still exists among providers and there is a further need to continue activities already supported under GFATM to minimize the stigma and create a more condusive environment for patients to seek and receive needed care.

Compared to the baseline survey, the end-line survey revealed that providers were more interested in additional trainings for all three focal diseases, even though observed differences were statistically not significant. Increased interest could be the result of increasing number of providers involved in service provision for focal diseases at the primary care level.

During the baseline survey, most of the primary care providers in surveyed facilities were unsatisfied with their working conditions, equipment and remuneration. They felt that their current salary was inadequate to their qualifications and therefore could not meet their essential needs. Analysis of data during the end-line survey showed that mean scores of providers satisfaction has increased but slightly.

Table 9 Providers' satisfaction scores

Motivation and satisfaction	*End-line*		*Base-line*		*t-value*	*p-value*
Motivation for working	**N**	**Mean**	**N**	**Mean**		
I'm proud to work in this facility	**201**	**4.3**	**105**	**4.5**	1.706	0.0889
This facility have very good reputation	**201**	**4.4**	**105**	**4.4**	0.207	0.8364
GF will have positive impact on providers motivation	**201**	**3.7**	**105**	**3.4**	-3.503	0.0005
Remuneration						
My present remuneration is according my knowledge, experience and capacity	**201**	**1.7**	**105**	**1.4**	-2.608	0.0099
My salary covers my essential needs (nutrition, transportation, lodging)	**201**	**1.6**	**105**	**1.4**	-2.504	0.0128
Per diems provided for outreach is enough	**201**	**1.9**	**105**	**2**	0.623	0.534
Efficiency						
I'm confident in my capacity to work efficiently	**201**	**4.4**	**105**	**4**	-3.259	0.0014
I'm supervising all activities of this facility	**201**	**2**	**105**	**2.3**	2.189	0.0299
I've gained knowledge and skills in this facility which has enriched my experience	**201**	**4.2**	**105**	**4.1**	-1.265	0.2075
Stock						
I've all needed equipment and supply to do my job	**201**	**2.9**	**105**	**2.4**	-2.676	0.008
Facility is providing all necessary supplies	**201**	**3.1**	**105**	**2.2**	-5.728	0
There is recourse shortage in the facility, which prevents me from doing high quality job	**201**	**3**	**105**	**3.3**	1.629	0.1043
Responsibilities						
My performance is of high quality	**201**	**4.3**	**105**	**4**	-2.336	0.021
I'm responsible and very accurate person	**201**	**4.6**	**105**	**4.4**	-2.608	0.0099
Quality of your performance is greatly affecting the health of the population	**201**	**4.4**	**105**	**4.3**	-1.644	0.1014
Satisfaction						
Are you satisfied with your current job?	**201**	**3.7**	**105**	**3.3**	-2.401	0.0171
Are supplies enough in the facility?	**201**	**3**	**105**	**2.3**	-5.255	0
Are you satisfied with skills and knowledge you gained in this facility?	**201**	**4.3**	**105**	**3.6**	-6.111	0

A more-detailed data analysis points to the fact that that providers involved in GFATM project activities and/or those that participated in trainings were more satisfied and accordingly more motivated than others (Table 10).

Table 10 Providers' satisfaction scores (participants and non-participants)

Motivation and satisfaction	*At present participating in GF program*		*At present not participating in GF program*		*t-value*	*p-value*
Motivation for working	**N**	**Mean**	**N**	**Mean**		
I'm proud to work in this facility	44	4.4	157	4.3	0.49	0.6264
This facility have very good reputation	44	4.5	157	4.4	1.507	0.1358
GF will have positive impact on providers motivation	44	4.6	157	3.5	9.585	0
Remuneration						
My present remuneration is according my knowledge, experience and capacity	44	1.8	157	1.7	0.186	0.8527
My salary covers my essential needs (nutrition, transportation, lodging)	44	1.5	157	1.6	-0.558	0.5795
Per diems provided for outreach is enough	44	1.9	157	2.0	-0.707	0.4812
Efficiency						
I'm confident in my capacity to work efficiently	44	4.5	157	4.3	1.268	0.2087
I'm supervising all activities of this facility	44	2.5	157	1.8	3.225	0.0022
I've gained knowledge and skills in this facility which has enriched my experience	44	4.3	157	4.2	0.202	0.8411
Stock						
I've all needed equipment and supply to do my job	44	2.9	157	2.9	0.044	0.9655
Facility is providing all necessary supplies	44	3.2	157	3.0	0.737	0.4656
There is recourse shortage in the facility, which prevents me from doing high quality job	44	2.9	157	3.0	-0.414	0.6813
Responsibilities						
My performance is of high quality	44	4.3	157	4.3	0.37	0.7136
I'm responsible and very accurate person	44	4.6	157	4.6	-0.322	0.7488
Quality of your performance is greatly affecting the health of the population	44	4.5	157	4.4	0.337	0.7384
Satisfaction						
Are you satisfied with your current job?	44	4.0	157	3.6	1.98	0.0516
Are supplies enough in the facility?	44	3.0	157	3.1	-0.141	0.8885
Are you satisfied with skills and knowledge you gained in this facility?	44	4.4	157	4.3	1.44	0.1542

Training of PHC providers on HIV/AIDS and TB related issues was the only activity planned under the GFATM funded project in primary health care facilities. Thus the main interest of research team was to look at the possible impact of trainings on PHC provider's knowledge, practice and attitude regarding focal diseases. No other significant changes were observed analyzing the survey data.

Laboratory Assessment

The HIV/AIDS component of the GFATM project was aimed at strengthening regional labs for HIV/AIDS services. Training of the staff, purchase of new equipment, improving lab management and quality control were planned for these purposes. Training of staff and procurement of essential equipment for Regional labs was done by the GFATM project for the moment of assessment. PCR equipment was purchased for the National AIDS center laboratory.

During baseline study, labs were selected based on prevalence rates of focal diseases, because at the time of the baseline study, GFATM implementation was delayed and the sites for lab investments were not defined. The same labs were actually selected by GFATM project later in implementation and they also were assessed during the end-line survey and included two central (national) and five regional laboratories and 25 lab technicians from these facilities were interviewed.

All labs had qualified staff. 3 laboratories are part of multi-profile hospitals and share support staff and technicians (engineers). The latest formal training undergone by staff was in 2007 in 2 central labs and 5 regional ones.

Three out of seven labs do not charge for services. All others have a formal pricing system in place and prices[5] vary from 3 GEL (~2 USD) to 25 GEL (~15 USD for HIV test). During the baseline survey it was assumed that GFATM supporting the labs for focal diseases may contribute to the process of decreasing prices for other services. In fact that has not happened. Compare to baseline, the prices for testing have increased, which can be explained by high inflation in the country in 2006-2007.

The survey team looked at available equipment (i.e., its presence and working condition) in the labs, trying to identify if GFATM contributed to the process of upgrading lab equipment. Essential equipment was present in all assessed facilities and all of them were in working condition. Microscopes were donated to all sentinel sites by GFATM, and hi-tech lab equipment[6] was made available to National AIDS centers lab. The process of equipping labs was not finalized at the time of the end-line survey.

The lab technician's survey revealed that the percentage of staff performing STDs and HIV/AIDS tests is higher in regional labs than in central (64.7% vs. 50% for STD's; 53% vs. 50 HIV/AIDS testing). Comparing to baseline data it is obvious that the number of providers who reported performing HIV and Malaria testing has decreased at the national level (HIV testing by 3% and Malaria by 8%). These findings probably points to the fact that lab services have become more geographically accessible in the country. Probably with the help of GFATM, the number of labs offering services outside the capital city increased, therefore decreasing geographical and financial access barriers to people in need.

One of most important positive impacts of GFATM is the fact that a number of the providers considering provision of care (testing) for infected people to be safe has increased significantly: for HIV/AIDS increased by 25% ($p<0.1$), for TB – increased by 38% ($t=-2.94$; $p<0.01$) and for Malaria by 43% (0 $t=-3.34$; $p<0.01$). In addition, 88% of the respondents mentioned that they are willing to participate in GFATM program and provide the services to the patients (80% HIV/AIDS, 88% TB and 88% Malaria).

[5] In Current prices
[6] Equipment for polymerase chain reaction PCR.

Table 11 Lab technicians' Satisfaction (baseline vs. end-line survey)

Motivation and satisfaction	*Baseline*		*End-line*		T test	
	N	Mean	N	Mean	t-value	p-value
Motivation for working						
I am proud to work in this facility	20	4.40	25	4.72	-2.206	0.0333
This facility has very good reputation	20	4.45	25	4.76	-2.159	0.0361
GF will have positive impact on providers' motivation	20	3.30	25	4.16	-3.755	0.0005
Remuneration						
My present remuneration is according my knowledge, experience and capacity	20	1.90	25	2.68	-2.917	0.0056
My salary covers my essential needs (nutrition, transportation, lodging)	20	1.65	25	2.52	-3.928	0.0004
Per diems provided for outreach is enough	20	2.35	24	2.83	-2.322	0.0264
Efficiency						
I'm confident in my capacity to work efficiently	20	4.40	25	4.48	-0.527	0.6015
I'm supervising all activities of this facility	20	2.25	25	2.76	-1.86	0.0692
I've gained knowledge and skills in this facility which has enriched my experience	20	4.30	25	4.48	-1.229	0.2264
Stock						
I've all needed equipment and supply to do my job	20	4.00	25	4.36	-1.773	0.0868
Facility is providing all necessary supplies	20	3.75	25	4.40	-2.728	0.0111
There is recourse shortage in the facility, which prevents me from doing high quality job	20	2.85	25	2.00	9.912	0.0000
Responsibilities						
My performance is of high quality	20	4.45	25	4.56	-0.721	0.4793
I'm responsible and very accurate person	20	4.65	25	4.28	2.354	0.0243
Quality of your performance is greatly affecting the health of the population	20	4.70	25	4.48	1.502	0.1409
Satisfaction						
I am satisfied with my current job	20	3.95	25	3.80	0.679	0.4982
Supplies are enough in the facility	20	3.70	25	4.44	-3.945	0.0004
I am satisfied with skills and knowledge I gained in this facility	20	4.15	25	4.56	-2.264	0.0314

As data shows, the satisfaction of lab technicians, like PHC providers, has slightly increased. This can be attributed to GFATM project, as for the moment of assessment; it was the only project targeting laboratories.

Access to Services

A high risk group population and HIV/AIDS[7], TB patients survey was added to protocol in Georgia at the request of Country Coordination Mechanisms, because it was seen as a very sensitive and important issue. The survey tried to identify main barriers to accessing services as well as beneficiary perceptions about what has (if anything) improved in the country after the GFATM project implementation. Information presented here is based on exit interviews and should be treated consciously, even may present the views of only those, who have an access to services.

Improved access to specialized care was mentioned as one of the main achievements of the project by almost all respondents. 100% of TB patients and 100% HIV/AIDS patients who needed treatment mentioned that access and availability of testing and treatment, including pharmaceuticals and consultations, had improved drastically since the GFATM project implementation. The biggest benefit for patients is the free of charge service provision for focal diseases. But unfortunately, the survey revealed that there is limited access to other services (than TB and HIV), which patients need. Interviewed AIDS patients has spend on overage 962.5 GEL during last year on medical care (other than HIV/AIDS) and TB patients – 300 GEL on overage. In both cases it was mentioned that amount is not acceptable, as vast majority are unemployed and are experiencing financial difficulties.

Based on interviews, there are several barriers to accessing general health care system in Georgia:

Stigma and confidentiality are important barriers that prevent patients with TB and HIV/AIDS from seeking care. HIV positive persons prefer not to seek care at all, because of health care provider attitudes. The issue of confidentiality was mentioned by both patients and representatives of high risk groups. Respondents are afraid that their status will be revealed to other people. IDU's were afraid of the possibility of being reported to police. It was also mentioned, that sometimes patients are rejected by medical staff after learning their HIV or TB status. This is more frequent among HIV positive persons.

Financial access barriers are also important. While access to specialized free services has improved as a result of GFATM funding, financial barriers still exist when other service are needed. HIV/AIDS and TB patients and representatives of HRG do not differ from the rest of the population. Such problems are common for any Georgian.

As a result of the GFATM the environment for HIV infected people has become friendlier (community support groups, networks for HIV positive individuals), especially after the creation of consultation centers for HIV infected people. These centers provide a place for gathering and problem-sharing among peers. One of the respondents mentioned:

[7] Survey questionnear for HIV/AIDS and TB patients has gone through the National Bioethics committee screening for approval.

"... I met other infected people in the center, now I can share my problems with them and as a result, I do not consider my own status the biggest problem as earlier. I am trying to help others and overcome these difficulties together with them…"

While during the baseline survey in 2005 the research team was not able to interview any HIV positive person, because people were against revealing their status, at the time of the end-line survey the research team was able to identify and interview 20 HIV positive individuals.

For TB patients, availability and access to free specialized services and free drugs has improved as well. However, the quality of the care provided has not yet been affected and it is more relevant in regional facilities. Findings of the study reveal that

management of two vertical programs (TB and HIV) differs significantly. HIV/AIDS patients were more satisfied with the quality of services than patients with TB. While the study was not looking at particular management issues of these programs and therefore can not identify the particular reasons for this difference, probably PR and MoLHSA should look at these issues more closely and try to remedy the situation.

Awareness on GFATM project is pretty low among beneficiaries (both patients and representatives of HRGs). Only those who have used specialized services and/or are the part of Methadone program have heard about the project. Also, knowledge levels differ between various high risk groups. The survey showed that IDUs are better informed about prevention measures than CSWs. Mass media along with the NGO's working in the field was identified as the main source for information regarding available services. Nevertheless, IDU partners/friends were also important and trusted sources of information. Peer group driven interventions are proving to be most effective according available evidence. Therefore, focusing more resources on peer-driven interventions and scaling them up should be given higher priority during future programming.

Client survey findings can be summarized as following:

- GFATM has improved availability and access to specialized services for HIV and TB patients. However the social and financial access barriers to general health care services still remain.
- GFATM funding created a more positive environment for HIV positive individuals. If during the baseline survey, patients refused to participate in the survey, during the end-line survey, it was possible to identify and interview 20 patients;
- While access to services has improved, the quality of the care for TB patients has not been affected yet and requires further efforts on the part of the Government to achieve quality improvements;
- Mass media and NGOs are critical sources of information for HRGs. But peer-driven interventions that generate more trust among HRGs should be prioritized during future programming phases.

Conclusions

GFATM funding for Georgia is not as significant as in many countries of sub-Saharan Africa. In 2006 GFATM contributions amounted to only 0.6% of Total Health Expenditures. Therefore, it is not expected that GFATM will have a major impact on Georgia's health system development. Nevertheless, this funding is critical for three focal diseases and has significantly improved the situation in these respects:

- GFATM has helped improve supply of needed materials and drugs, and increased availability of free services for focal diseases;
- Trainings funded under the GFATM, have been instrumental to improve capacity of providers, lab technicians and NGOs, which in itself has helped improve delivery of services to patients/clients;
- Investments made in human resources and equipment have increased geographical availability of services for focal diseases and helped reduce geographical access barriers to treatment and care;
- Drugs funded under GFATM helped to achieve 100% ART coverage and improved availability of anti TB treatment;
- Interventions funded by GFATM also helped to change primary care providers' attitudes towards TB, HIV/AIDS and malaria patients. Mainly they helped improve provider perceptions and increased number of those providers who are not afraid of these diseases and express readiness to deliver services to the patients that are ill with HIV/AIDS, TB and Malaria.

While TB, HIV and malaria patients have benefited from free services because of GFATM funding, access to general health care is yet still limited due to financial barriers, which are common to many Georgians. However, on top of financial access barriers, these people are also faced with stigma and confidentiality issues that are widespread in the health care system of Georgia and prevent many HIV and TB patients from seeking care for general health problems. GFATM projects could further their interventions as well as work on policy matters to mitigate the issues related to stigma and confidentiality.

Increased availability of GFATM funds helped the Government to move state budget funds towards different health care priorities. During 2001-2006, public expenditures (in current prices) on health grew on average by 23% annually, but allocations for focal diseases increased only marginally for TB and Malaria and declined for HIV/AIDS. Besides, budgets for preventive interventions declined sharply and curative interventions received higher public allocations. Therefore, GFATM's expectations that the GoG would raise allocations for focal diseases have not been met and currently service provision of focal diseases is much dependant on GFATM funds. This raises a lot of concerns among stakeholders as a threat for sustainability of the program, GFATM has to pay more attention to this fact.

GFATM also helped increase service availability and to reach more individuals with preventive, diagnostic and curative services, consequently increasing recurrent cost requirements. In addition, expected growth of the size of the epidemic may demand more recurrent resources, consequently aggravating existing funding shortages. Therefore, most people interviewed by the research team expressed concerns about

sustainability of GFATM funded interventions. During the coming years it is unlikely that the GoG will fully replace these funds if GFATM funding stops abruptly. Therefore, GFATM has to develop a gradual exit strategy, which could span 10-15 years, taking into account changes in the epidemic and always considering the macroeconomic conditions of the country and changes in the health care financing. Such an approach will help shield and sustain achievements realized thus far.

Policy analysis and review of the submitted proposals revealed that GFATM financed projects were all in line with main strategic documents and have not negatively influenced the health sector reforms being implemented by the GoG. The strategies aimed at strengthening HIV/AIDS and Malaria services will further reinforce the vertical nature of these programs. Nevertheless, proposals for improved TB service delivery are aimed at integration of these services into primary health care. Based on the available evidence we consider that the participatory nature of the CCM and quality leadership and improved coordination which emerged after the baseline have all contributed to development of quality GFATM proposals that will either have neutral effect on the overall health care system or will strengthen it.

Finally, overall monitoring and evaluation of GFATM financed interventions remains to be weak. Effective functionality of this system is essential to a) monitor the effectiveness of the implemented interventions and their impact on epidemic spread and b) to evaluate overall impact of the GFATM on the health care system. However, most respondents highlighted weak national capacity of M&E and the need for external technical assistance. In addition, CCM has to become more focused on timely receiving M&E results and using emerging evidence for future planning and proposal development. Therefore, Georgia has to focus more on developing and institutionalizing an adequate M&E system.

Finally, GFATM funded activities for HIV/AIDS have helped to create social networks, which have allowed PLWHA to meet and exchange information, better understand their health problems and eventually helping these individuals to become more open about their HIV status. So, peer-supported and driven interventions seem to have great potential in Georgia. It seems necessary to increase the scale of such interventions to effectively respond to the HIV/AIDS epidemic in the country.

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Annexes

Annex 1 In-depth Interview Guide for Stakeholders

1. Respondent's Name _____

2. Institution (organization) _____

3. Address _____

4. Position _____

5. Briefly describe your role and function in the GFATM program (proposal preparation, planning and implementation).

- ⇒ What is your role now in implementation/planning of GFATM strategies/processes?
- ⇒ Are you a member of CCM? Yes/No
- ⇒ What has been your main involvement in the CCM?
- ⇒ Please, describe what has been done in the project since implementation has been started?
  - ⇒ Prevention component (implemented activities)
  - ⇒ Treatment component (drug procurement, trainings for human recourses)
- ⇒ What do you plan to implement during next 6/12 months?
  - ⇒ Scheduled trainings
  - ⇒ Planed activities

6. How did you first get involved in the Global Fund process / in the CCM?

7. How would you assess overall effectiveness of the CCM? Is it functioning in effective way in decision-making processes? If yes, why do you think so? If no, why?

8. When was last time when you attended CCM meeting?

9. What particular aspects were discussed?

10. In general, how frequently do CCM members have meetings and how decisions are made?

11. Are there any organizations in the CCM who are the actual implementers of the GFATMATM program? If yes, is there conflict of interest?

12. What has been changed in the structure of CCM since March, 2004 in terms of composition? Which persons/organizations were added/excluded from the initial list?

13. Has your organization special person/structure that is responsible for the GFATMATM program related activities? If yes, who is responsible for that?

THEME B:
CCM and proposal preparation Explore issues around CCM structure (composition), process and content:
B.1. During tender process and project implementation phase (and proposal preparation only for TB proposal), how well did the CCM work in terms of its *composition*? What was the main role of the CCM in case of tender process? And what was the main involvement of the CCM in actual implementation of the project up to date? Please list main functions of the CCM in general with regard of the project implementation.

⇒ *Are there right people on the CCM?*
⇒ *Who is not involved who should have been? If yes, why did this happen?*
⇒ *Roles on the CCM – chairman, secretary; how well these roles are filled?*

B.2. How well did the CCM work in terms of members' *representation* of the different constituencies?

** If possible, it may be useful to cross check views on the nature and quality of representation with some member constituents.

⇒ *Were members representing different constituencies (MoH, National AIDS Council, other ministries, bilaterals, multilaterals, NGOs, civil society, faith-based groups [focus here particularly]?*
⇒ *** What is the 'legitimacy' of agency representation – for example with NGOs, faith based and private-for-profit organizations what is their size, composition, national coverage.*
⇒ ***How well did they carry out this representation? What are the channels for informing and consulting constituents – explore frequency and quality. What factors help/hinder the frequency and quality of representation*
⇒ *Conflicts of interest (e.g. are CCM members perceived to be trying to gain an advantage for their own organizations)?*

B.3. What were/are the CCM *processes during project implementation phase* and their ways of working? How well these works?

⇒ *Process: frequency of meetings – about right/too many/too few? Why did this happen?*
⇒ *Frequency of attendance by different members? Reasons for non-attendance? Attendance at key meetings where decisions were made?*
⇒ *Use of working groups? Sub-committees? **Secretariats? How did these interface with CCM?*
⇒ *** Has the CCM agreed principles of conduct (e.g. quorums for voting)*
⇒ *Delegation of activities to outsiders?*
⇒ *Communication between members?*
⇒ *Quality of contributions from different CCM members? If patchy, why?*
⇒ *Selection of proposals – how did the CCM achieve a balance between the 3 diseases? between different groups seeking funding? between different interventions (prevention, treatment, care)?*
⇒ *How did decision making processes work? How was consensus reached? How was contention handled?*

B.4. *Accountability*: relationship / reporting between CCM and Government
Different perceptions of government and GFATM; pressure from GFATM?

B.5. *Communication*: with non-CCM members

⇒ *Between representatives and their constituencies?*
⇒ *Contributions / inputs from non CCM members?*

B.6. *Content*: how successful was the CCM in achieving its objective of producing a plan for future activities and proposal for submission (for TB proposal)? What were the reasons for this?

⇒ *A proposal that was likely to be funded? *(for TB)*
⇒ *A proposal that fitted with country priorities and systems realities?(for TB)*

B.7. *Overall*, what worked well in the CCM process? What not so well?

⇒ *Explore if the CCM process has resulted in new or better ways of working between the different constituencies; notably in involving NGOs and other actors; and also if it has had any negative effects in relationships.*

B.8. What *improvements* in the CCM were implemented between rounds 1, 2 and 3? Where (if at all) did the CCM *not improve* the way it worked? Where was there room for further improvement? (For TB)

B.9. What *improvements* in the CCM were implemented between proposal preparation, tender processes and actual implementation of the project? Where (if at all) did the CCM *not improve* the way it worked? Where was there room for further improvement?

THEME D.
Communications with Global Fund and others during proposal preparation
(Only for TB proposal)

D.1. What were the communication links between the MoH / CCM and the Global Fund?

- ⇒ *with the TRP, Secretariat, GFATM Board, Working Groups (Working Groups)*
- ⇒ *Forms of communication – emails, phone calls, post/fax, country visits, other? How did these affect transparency and equity of access for different CCM members?*
- ⇒ *explore for formal and informal links (through CCMs and informally through other channels)*
- ⇒ *involvement of country policy makers on GFATM committees providing an advantage; perceptions that other countries had prior knowledge and had an unfair advantage;*
- ⇒ *Changes / improvements in communication between rounds 1, 2 and 3.*

D.2. Communication with others

- ⇒ *other countries submitting proposals (shared lesson learning or competition)*

D.3. *(for public institutions)* **What are the communication links with other public institutions/with private institutions?**

D.4. What are the communication links between the MoH / CCM and the Global Fund during actual implementation of the project?

- ⇒ *with the TRP, Secretariat, GFATM Board, Working Groups (Working Groups)*
- ⇒ *Forms of communication – emails, phone calls, post/fax, country visits, other? How did these affect transparency and equity of access for different CCM members?*
- ⇒ *explore for formal and informal links (through CCMs and informally through other channels)*
- ⇒ *involvement of country policy makers on GFATM committees providing an advantage; perceptions that other countries had prior knowledge and had an unfair advantage;*
- ⇒ *Changes / improvements in communication between rounds 1, 2 and 3.*

THEME E.
Technical support to project implementation and proposal preparation (only for TB proposal)

E.1. From outside of country
E.2. Country-level technical support

THEME F.
Feedback from GFATM / TRP

F.1. Quality of feedback to CCMs from Global Fund (note which section of GFATM)?

- ⇒ *Handling of queries / requests for clarification from countries / CCMs*
- ⇒ *Feedback from TRP*
  - ◊ *quantity, quality, coherence, timeliness, etc.;*
  - ◊ *perceptions of appropriateness of technical expertise (disease versus systems expertise; knowledge of TRP members of country contextual issues)*
  - ◊ *consistency in TRP assessments (conflicting advice given to different countries)*
- ⇒ *Changes / improvements in feedback between rounds 1, 2 and 3, especially around TRP.*
- ⇒ *Feasibility of achieving targets*

THEME G.

Co-ordination with existing policy, planning and funding processes

G.1. During proposal preparation, how did the Global Fund way of working fit with existing country processes for policy making and strategic planning for HIV/AIDS, TB and malaria control?

- ⇒ *Influence on policy making and prioritization? Positive and/or negative? How?*
- ⇒ *Co-ordination of GFATM processes with pre-existing ways of working?*
  - ◊ *National Health Strategic Plans?*
  - ◊ *Swaps and Annual Health Sector Reviews?*
  - ◊ *PRSPs?*
- ⇒ *Timing of application process (in relation to other priority activities / end of financial year)?*
- ⇒ *How well the 'fit' worked*
  - ◊ *Duplication of efforts*
  - ◊ *Distracted / diverted senior ministry and other staff from other priorities (see later)*
  - ◊ *Others effects?*

G.2. What impact did the GFATM application process on the quality of strategic plans for the 3 diseases?

- ⇒ *What changes had to be made to existing strategic plans (for HIV/AIDS, TB, and malaria control)? What mix of positive and/or negative effects did it have on pre-existing plans?*
- ⇒ *How (if at all) was capacity for strategic planning affected (improved? No change?)?*

G.3. Overall, what was the mix of positive and/or negative effects on policy and strategic planning?

- ⇒ *What problems (if any) encountered? How these were solved? Lessons learned?*
- ⇒ *Changes / improvements in co-ordination of policy and strategic planning for the 3 diseases between rounds 1, 2 and 3.*

G.4. Co-ordination with existing budget policies and sources of funding?

- ⇒ *Macroeconomic effects – level of new (GFATM) funding might conflict with MoF budget ceilings?*
- ⇒ *Uncertainties as to what was the level of unmet need to fill – uncertainties about future levels of funds from existing sources, including bilateral donors, debt credits (PRSPs), budget support?*
- ⇒ *Evidence of additionally?*
- ⇒ *Uncertainties around timing of arrival of new funds and how this would affect budget cycles?*

G.5. How much time was spent by different key stakeholders in preparing proposals (*'transaction costs'*)?

⇒ *Explore respondent's views and try to estimate how much of (a) his/her own time (b) and how much of key others (senior policy makers) time went into it*

⇒ *Check for changes / improvements between rounds 1, 2 and 3*

G.6. Did other activities or priorities suffer in any way through spending time on proposal preparation? In what way? (*'opportunity costs'*)

⇒ *Explore respondent's views in-depth for his/her own time; and then for key senior policy makers*

⇒ *How would he / they have spent that time if there was no Global Fund?*

⇒ *What activities (if any) were affected?*

⇒ *How (if at all) were these other activities affected?*

- ◊ *temporarily delayed but undertaken adequately at a later point?*
- ◊ *Temporarily delayed and done but not adequately at a later point?*
- ◊ *Not yet done / omitted altogether?*

⇒ *Check for changes / improvements between rounds 1, 2 and 3*

G.7. On balance, was participation in the CCM/ proposal preparation a worthwhile use of your (their) time? (*see earlier issues around costs and benefits*)

⇒ *Explore what criteria they would use to make such a judgment*

- ◊ *A successful application and arrival of funds*
- ◊ *If GFATM funds are truly additional*
- ◊ *If GFATM are available long-term (for how long? How many years?)*
- ◊ *Other reasons?*

THEME I.

Implementation

I.1. Was tender process equitable for all applicants? Were all NGOs in the same position and have they similar rights to participate in the tender? (CCM members/ Non-CCM members)

⇒ *conflict of interest*

I.2. Did CCM use the same criteria for selection process as Government? If not, what is the difference?

I.3. After finishing GFATMATM program, will Ministry use the selection criteria, which has been used by GFATM?

I.4. What is existing role of CCM in planning for implementation?

⇒ *Explore*

I.5. How (if at all) have implementation plans developed and taken shape since the country was informed that its proposal was successful?

⇒ *What has been the process? – explore*

⇒ *Who has been involved? Has it been through the CCM, or handled in a different way?*

⇒ *What has been the role of the CCM in planning for implementation? Has its role evolved / changed? In what way?*

⇒ *Check for composition of CCM and strategic planning group(s), if any. Who has dropped out and who has been added to the CCM since the proposal preparation phase (note if MoH is reeling in the process, now that funds are expected)? What are the effects of these changes?*

⇒ *How well is the CCM functioning? How, if at all, are processes different to the proposal preparation phase? Evidence of improvement over time?*
⇒ *NOTE: Try to get copies of CCM / planning meeting minutes.*

I.6. What communications / interactions have there been with the GFATM Secretariat? Or other informal communications with the GFATM?
⇒ *How are communications being channeled? Between who (at country level) and who at GFATM?*
⇒ *What are the various modes of communication (email, phone, letters, fax, visits of GFATM to country, visits by country staff to meetings outside).*
⇒ *Have there been informal as well as formal communications?*
⇒ *Is there evidence of improvements in communication from the GFATM over time?*

I.7. Has the necessary technical support been available for strategic and activity planning?
⇒ *External support – availability, source, adequacy, cost*
⇒ *In-country support – availability, source, adequacy, cost*

I.8. Channeling of GFATM funds and role of Principle Recipient (PR)
⇒ *Who is (are) the PR(s)? Is there consensus around this choice? If not, why not?*
⇒ *What is the role of the PR?*
⇒ *How will GFATM funds be inputted into the health sector?*
  ◊ *Vertical channeling through MoH*
  ◊ *Budget support*
  ◊ *Health sector basket (Swap)*
  ◊ *Other mechanism (note Uganda = vertical outside of MoH because of budget ceiling)?*
⇒ *How well do plans for channeling GFATM funds fit with existing funding mechanisms? – explore*
⇒ *Who received GFATM funds (check on breakdown between MoH, NGOs, others?)*
⇒ *What are the relationship of the CCM and PR? Issues around reporting, accountability, oversight responsibility of CCM?*

I.9. How will activity planning for GFATM HIV/AIDS, malaria, TB fit with decentralized / bottom-up planning processes?
⇒ *Is there risk of re-verticalisation of planning and management? How is this viewed?*
⇒ *Is there risk of 'disintegration' in management and service delivery for the 3 diseases? How is this viewed?*

I.10. What elements need to be in place to increase the chances of successful implementation?
⇒ *Explore*

I.11. What technical support has been provided/is needed for successful implementation? What kind? Where will it be sourced?
⇒ *In-country – MoH sufficient, multilateral agencies, bilateral donors?*
⇒ *External – multilateral agencies, bilateral donors, others*
⇒ *What support or guidance from the GFATM?*

I.12. Concerns around equity in implementation plans?

⇒ *Focus, especially for HIV/AIDS treatment, likely to be on urban settings / large centers?*
⇒ *How to select individuals for scarce ART?*

I.13. What are the biggest obstacles to successful implementation

Issues may already have been covered above

⇒ *Limited capacity leading to failure to spend money well (limited absorptive capacity)?*
⇒ *Ambitious (unrealistic) targets*
⇒ *Others?*

- Timeliness and process of GFATM funds disbursement [8]

⇒ *What are the 'milestones' (conditions) for signing agreements and disbursement? Have these been clear to countries?*
⇒ *Did countries achieve these milestones? If not, why not? Which ones were not achieved?*
⇒ *** How was the process of grant signing handled? Did all go to plan? How did it compare to other grant agreement processes?*
⇒ *Has disbursement occurred according to schedule? ** If not, at what level of the disbursement chain are blockages occurring? **What are the reasons for this? **What is being done about it – by whom? **How does this compare to the disbursement of other grant initiatives (e.g. MAP)?*
⇒ *What communication have you had from GFATM Secretariat about plans for disbursement? ** If/ where disbursement is behind target how informed is the GFATM Secretariat about progress – what is their reaction/input?*
⇒ *What consequences have delays in disbursement had?*
  ◊ *On existing programmes (e.g. cross-cutting activities delayed due to delay in funding)*
  ◊ *On implementation of GFATM plans*
  ◊ *On macroeconomic projections for overall health sector budgeting*

- **Procurement of drugs (for HIV, TB, malaria) and commodities (e.g. ITNs, lab supplies, etc.)**

⇒ *What new drugs and commodities are procured or will need to be procured (check with GFATM application)*
⇒ *What plans do the MoH/ country have for procuring these?*
⇒ *Which were procured or will be procured within the country and which from outside (estimated value of each)?*
⇒ *How have decisions been made as to where / from whom to source these?*
  ◊ *Advice, guidance, criteria, conditions for procurement received from GFATM? Adequate information? sufficient flexibility?*
  ◊ *Influence / pressure from other stakeholders on procurement choices?*
  ◊ *Tendering process undertaken so as to source cheapest reliable source? Availability of information so as to do this?*
  ◊ *Collaboration with other countries?*
⇒ *How do procurement plans fit with pre-existing country procurement processes? integrated or parallel systems planned?*
⇒ *Views as to the appropriateness of procurement plans?*
⇒ *Plans/evidence of discussions for waiver or removal of tariffs on imports and removal of VAT from processed commodities*

[8] The actual timing of disbursement (whether it has occurred or is still planned) will dictate these questions.

- **Financial management and role of LFA**

⇒ *Who has been selected to be the Local Fund Agent (LFA)? Is there consensus around this choice? If not, why not?*
⇒ *What is the role of the LFA?*
⇒ *What communications have they had from the GFATM or what have they heard about the proposed LFA process?*
⇒ *How will the LFA process fit with existing financial management systems? Any problems envisaged? Views as to the appropriateness of this system?*

- **Monitoring and Evaluation**

⇒ *What plans are there for monitoring and evaluating GFATM funded activities?*
⇒ *How onerous are they (e.g. 3 monthly reporting)? How will they 'fit' with existing systems?*
⇒ *What communications have they had from the GFATM or what have they heard about the proposed monitoring and evaluation process?*
⇒ *How much reliance do they think can be placed on existing information systems for M&E?*
⇒ *If future GFATM funding depends on demonstrating improved performance, do they expect this will affect the reliability of M&E / information systems*
⇒ *In what way (if at all) is GFATM M&E likely to lead to greater in-country capacity for M&E?*

I.2 from here forwards

When (now that) funds have arrived, what are the biggest challenges to implementation and scaling up of HIV/AIDS, malaria and TB control activities?

⇒ *Probe for at least 3 and follow up on and explore each of them (note if human resources is spontaneously mentioned)*
⇒ *Ask about capacity limitations and possible bottlenecks*
⇒ *If not volunteered, ask about Human Resource plans*
  ◊ *What sort of planning has been done. NOTE: try to get plans*
  ◊ *Adequacy or shortages – in which professions or categories of staff and specialties; by disease; by geographical location*
  ◊ *Plans for filling human resource gaps – probe and explore*
    - *by involving NGOs, communities, private sector*
    - *training new staff (ask about time-scale to accomplish this)*
    - *redeployment of existing staff (from what programmes? What impact on other programmes?)*
⇒ *How will capacity-building be funded (from GFATM funds or other sources)?*

Annex 2 NGO assessment tool (for follow-up survey)

Organizational structure and management	
1.	Organization Name:
2.	Legal status:
3.	Position of interviewed person:
4.	Organization mission:
5.	Organization strategic aims and objectives:
6.	Has or no organization board?
7.	What is the structure of the organization?
8.	Overall function of the board
9.	Past experience: Number of implemented projects
10.	Budget size of each of the projects
11.	Donors
12.	Main field of activity
13.	Is NGO CCM member
14.	Number of professional staff
15.	Number of administrative staff
16.	List of service provided by NGO (type of services, target population/groups)
17.	Do you monitor the quality of services you provide? If yes, how?
18.	Do you provide any drugs to your clients?
19.	If yes, do you have any special place where you keep medications?
20.	Do you have any special place where you keep the medications?
21.	Does your facility determine the amount of each medication required and orders this amount, or is the amount that you receive determined elsewhere?
Program Planning, implementation, monitoring and evaluation	
22.	Who is responsible for planning process?
23.	Has organization annual plan?
24.	What does annual plan indicate?
25.	Is their regular evaluation of the staff? If yes, how often?
26.	How do you measure the work plan?
27.	How do you evaluate monitoring process?
28.	Who provides reports to stakeholders?
29.	What needs to be done in order to develop the necessary organizational capacity?
30.	How well are the various departments equipped with the necessary human recourse skills?
31.	Is it relevant the number of staff members?
32.	Who carry out performance appraisals of their superiors?
33.	How well known are the rules and regulations?
34.	To what extent are tax collection, budgeting, accounting and auditing systems effective and modernized? (describe the process)
35.	How successful is the teamwork in achieving its objectives?
36.	Do you have regular donors?
37.	What kind of funding sources are available?

38.	Do you carry out internal and external audits?
39.	Who carry out financial reporting?
40.	Who is responsible for recording and reporting of financial information?
41.	How are resources (human, material) distributed?
42.	How do you evaluate infrastructure of you office?
43.	Does your office adequately equipped with informational technology?
44.	What mechanisms exist for both formal and informal communication?
45.	What is the relationship between organization and stakeholder?
46.	What are communication links between NGOs, companies and government authority?
47.	How achieve is the board in decision making process
48.	What is the relationship between administrative and professional staff?

Annex 3 In-depth Interview Guide (For patients)

1. Respondents age _____

2. Respondents gender 1. Men 2. women

3. How long have you been a patient at this clinic?
   Less than one month
   One month to one year
   One to five years
   More than five years

4. Who recommended you this doctor?
   - *Friend*
   - *Family member*
   - *Girlfriend/boyfriend*
   - *Other (specify)*

5. Why you choose this doctor?
   - High professional skills
   - I am sure his/her confidentiality If no why?
   - Timeliness
   - Friendliness
   - Comfortable environment
   - Other (specify)

6. Now I want to ask specifically about services for HIV/AIDS/TB. Are HIV/AIDS/TB services being offered at the facility? (Specify)

7. Are you satisfied with services in AIDS Center/TB dispensary? If yes, why? If no, why?
   - *Quality of care (correctness of diagnosis and tests)*
   - I have no doubts about the ability of doctors who treated me
   - *Relations with medical staff*
   - *Confidentiality*

8. I think my doctor's office has everything needed to provide complete medical care
   - *Technical equipment*
   - *Drugs*
   - *Nursing care*
   - *Laboratory department*
   - *Medical records*
   - *Availability of hospital beds*

9. Do you receive any free services from the state program? If yes, specify.
   - Drugs (*you buy entirely or AIDS Center has mostly?*)
     Where did you get drugs?
     Which drugs do you buy?
     Is it easily accessible drugs? If yes, why? If no, why?
   - tests
   - consultations
   - free examinations
   - free bed availability in the aid center

10. Are you satisfied with services which provide you state program? If yes, why? If no, why?

11. In the last 12 months, have you always seen the same doctor when you come to the clinic? If yes, why? If no, why?
    (Relationship with your doctor)

12. Have you easy access to the medical specialists you need (outside the clinic)?
    - *To the dentist*
    - *To the gynecology*
    - *To the dermatologist*
    - *To the internist*

13. If no, what barriers do you face when you need any other medical care (outside the clinic)? (Specify)

14. Would you recommend this Center to others? If yes why? If no why?

15. Have you heard about GFATM project?

16. If yes, please specify from where?

17. Please specify what do you know about the GFATM project and its activities?

18. Has anything changed from the perspective of services, since the GFATM project started?

19. If yes, please specify what has changed?

Below are some things people say about medical care. Please read each STATEMENT carefully, keeping in mind the medical care you are receiving now at our facility. We are interested in your feelings, good and bad, about the medical care you have received.

15. How strongly do your AGREE or DISAGREE with each of the following statements? (Circle only ONE number in each line)

	Strongly Agree	**Agree**	**Uncertain**	**Disagree**	**Strongly Disagree**
1. Doctors are good about explaining the reason for medical tests	1	2	3	4	5
2. I think my doctor's office has everything needed to provide complete medical care	1	2	3	4	5
3. The medical care I have been receiving is just about perfect	1	2	3	4	5
4. I would you recommend this facility to my family members and friends?	1	2	3	4	5
5. Sometimes doctors make me wonder if their diagnosis is correct	1	2	3	4	5
6. I feel confident that I can get the medical care I need without being set back financially	1	2	3	4	5
7. When I go for medical care, they are careful to	1	2	3	4	5

15. How strongly do your AGREE or DISAGREE with <u>each</u> of the following statements? (Circle only ONE number in each line)					
	Strongly <u>Agree</u>	**<u>Agree</u>**	**<u>Uncertain</u>**	**<u>Disagree</u>**	**Strongly <u>Disagree</u>**
check everything when treating and examining me					
8. I have to pay for medical care than I can afford	1	2	3	4	5
9. I have easy access to the medical specialists I need	1	2	3	4	5
10. Where I get medical care, people have to wait too long for emergency treatment	1	2	3	4	5
11. Doctors act too impersonal toward me	1	2	3	4	5
12. My doctors treat me in a very friendly and courteous manner	1	2	3	4	5
13. Those who provide my medical care sometimes hurry too much when they treat me	1	2	3	4	5
14. Doctors sometimes ignore what I tell them	1	2	3	4	5
15. I have some doubts about the ability of doctors who treat me	1	2	3	4	5
16. Doctors usually spent plenty of time with me	1	2	3	4	5
17. I find it hard to get an appointment for medical care right away	1	2	3	4	5
18. I am dissatisfied with some things about medical care I receive	1	2	3	4	5
19. I am able to get medical care whenever I need it	1	2	3	4	5
20. I would you recommend the <u>physician</u> I saw to my family members and friends?	1	2	3	4	5

21. Which facility/specialist you have visited during last 6 month? 1. _____

22. How much money did you spend for medical care in last 6 month? _____

23. Is spending money acceptable for you? _____

23. Please, write down today's date month_____ Day_____ Year _____

Annex 4 In-depth interview Guide (for the high risk groups)

Questioner identification number **Age of interviewed person:**
Location of the interview: **Date:_____**

Location :1.Tbilisi 2.Bbatumi 3. Kutaisi

Institution:_____ **Name of the interviewer:**

Introduction: My name is . . . . . . The Aim of the research we are implementing is to asses impact of the resources which were give out by Global Fund for recipient countries Health Care systems. The Research is implemented by EU investment within "Possible impact of the projects, invested by the Global Fund for recipient countries Health Care systems" project.
I intend to ask you few questions about HIV/AIDS, TB and Malaria; your answers are strictly confidential.
You are not required to answer the questions which you do not want to. We though your answers give us opportunity to improve medical health service.

1. How old are you? (Please, indicate precise age)_____
2. Have you heard something about the following diseases? *(For moderator: circle proper answer)*

- HIV/AIDS yes / no
- TB yes /no
- Malaria yes / no

3. If yes, how do you know information about this disease?

	HIV/AIDS	**TB**	**Malaria**
friend			
Family member			
Partner (sexual)			
Partner(drug user)			
Health worker			
Mass-media			
Others (precise)			

(The Moderator: let us discuss HIV/AIDS)

4. Do you know someone (have you heard or know someone personally from your friend, Neighbor or family member) who is infected, ill or died with AIDS) ----------
---

--

5. I do not want to know the result, but have you taken AIDS lab-test?

If yes, go to question 5.2

5.1 If no, why? (For moderator: Do not read the list)

- I am not interested in analysis results.
- I have the fear of results.
- I observe rules of safety (please specify)

_ Other (please specify)

5.2 If yes, why? (For moderator: Do not read the list)

- I am always interested in my health status
- I had some doubts (my partner had some doubts)
- Thought it necessary

_ Other (please specify)

---

6. Have you received any medical service in AIDS center?

Yes _____
No _____ if no, move to the question 8

If yes, which kind of service?

Consultation	
Testing	
Treatment	

7. Are you satisfied with their service? If yes, why? If no, why?

---

8. Do you intend to receive the service from this center in the future? If yes why? If no why?

---

9. Do you know something about AIDS prevention and transmission? (Please specify)
If no, move to question 10.

9.1 If yes, who spoke with you about this?

- Doctor
- Social worker
- Nurse
- Other med-personal
- Family member
- Partner (for the Interviewer: ask the people who are addicted to drugs about sexual partners and partners in using drugs)
- Friend
- Other (please specify)

---

10. Did you receive information from any information service about AIDS prevention and transmission ways?

Yes _____
No _____

If yes, from which information service?

- Television
- Newspaper
- Internet
- Booklet
- Other (Please specify)

(Moderator: Let us discuss TB)

11. Do you know someone (have you heard or know someone personally from your friend, neighbor or family member) who is infected, diseased or died with TB?

---

12. I do not want to know the result, but have you provided TB lab-test?

If yes, move to the question 12.2

12.1 If no, why? (For Moderator: Do not read the list)

- § I am not interested in analysis results.
- § I have the fear of results.
- § I observe rules of safety (please specify)

__Other (please specify)

12.2. If yes, why? (For Moderator: do not read the list)

__ I always have interest in my health condition.
__ I had certain suspicions. (My partner also had certain suspicions)
__ For requirement. (Please specify)

__ Other (Please specify)

---

13. Have you received any service in the TB dispensary?

Yes _____
No _____ **If no, move to the question 15**

If yes which kind of service?

Consultation	
Testing	
Treatment	

14. Are you satisfied with their service? If yes why? If no, why?

---

15. Do you intend to receive the service from this center in the future? If yes why? If no why?

---

16. Do you know something about TB prevention and transmission? (Please specify)

If no move to the question 17

16.1 If yes, who spoke with you about this?

- Doctor
- Social worker
- Nurse
- Other med-personal
- Family member
- Partner (for the Interviewer: ask the people who are addicted to drugs about sexual partners and partners in using drugs)
- Friend
- Other (to be précised)

17. Did you receive information from any information service about TB prevention and transmission ways?

Yes_____
No_____

If yes, from which information service?

- Television
- Newspaper
- Internet
- Booklet
- Other (Please specify)

(Moderator: Let us discuss Malaria)

18. Do you know someone (have you heard or know someone personally from your friend, neighbor or family member? Who is infected, diseased or died with Malaria?

---

19. I do not want to know the result, but have you provided Malaria lab-test?
If yes, move to the question 19.2

19.1 If no, why? (For the Moderator: Do not read the list)

- I am not interested in analysis results.
- I have the fear of results.
- I observe rules of safety. (Please specify)

__Other (Please specify)

---

19. 2 If yes, why? (For the Moderator: Do not read the list)

- I always have interest in my health condition.
- I had certain suspicions (My partner also had certain suspicions)
- For requirement (Please specify)

__Other (Please specify)

---

20. Have you received any service in case of Malaria?

Yes____
No ____ **If no, move to the question 22**

If yes, which kind of service?

Consultation	
Testing	
Treatment	

21. Are you satisfied with their service? If yes why? If no why?

---

22. Do you intend to receive the service from this center in the future? If yes way? If no way?

---

23. Do you know something about Malaria prevention and transmission? (Please specify)
If no move to the question 24

23.1 If yes, who spoke with you about this?

- Doctor
- Social worker
- Nurse
- Other med-personal
- Family member
- Partner (for the Interviewer: ask the people who are addicted to drugs about sexual partners and partners in using drugs)
- Friend
- Other (Please specify)

---

24. Did you receive information from any information service about Malaria prevention and transmission ways?
Yes ____
No _____

If yes, from which information service?

- Television
- Newspaper
- Internet service
- Booklet
- Other (Please specify)

---

25. In case you need medical help in any health care centre, is it easily affordable for you?
Yes----------
No ----------
If no, which kind of resistance do you meet? (Please specify)
---

26. Have you heard about GFATM project?
Yes/No

If no, please finish the interview

27. If yes, from where have you heard about it?

- Friend
- Family member
- Partner (sexual)
- Partner (drug user)
- Health worker
- Mass-media
- Others (precise)

28. What exactly do you know about the GFATM project and its activities?

---

29. Had anything changed for you since GFATM project initiation with regard of receiving healthcare services?

---

30. If yes, what has been changed?

Annex 5 Provider Survey

Information about Interview

F1 interview started _____ _____
F2Date:_____ Interviewer _____

Introduction

Hello, we are conducting facility survey in the frames of the survey " Monitoring and Evaluating the Health System-Wide Effects of the Global Fund to Fight AIDS, Tuberculosis and Malaria". Information provided by you will be confidential. The research aims to asses the GFATM impact on recipient countries health care systems. Are you welling to participate in survey?

_____ _____
F3 Indicate respondents answer F4 Date

1. yes 2. no

Information about Facility

F5. Facility Name _____

F6 1. City/Village 2.Rayon

F7. Facility type:

1 = Village/City Policlinic 2= Other _____

Legal status of facility:

1= State _____
2 = Private _____

Exact address of the facility_____

Information about provider

F8 Status:

1=Doctor Position (Please indicate): _____

F9 Sex: 1=Female 2=Male

F10 (Ask in the regions only) have you attended/participated in the trainings conducted within GFATM program "Integration of PHC level in modern system of TB control" (DOTS), conducted by TB and lung diseases national center?

1. yes
2. no

Section 1. Providers education, position, experience			
No.	**Questions**	**Answers**	**Go to**
1.	How many years are you working in this facility?	Years _____	
2.	When you graduate from Medical/nursing school?	☐☐☐☐	
3.	What is you position in this facility?	Doctor ..... 1 Nurse ..... 2 Auxiliary nurse ……..3 Midwife……..…….…….4 Other_____.....5	
4.	What type of contract you have with this facility?	Temporary ……1 Permanent…….. 2	
5.	Are you providing care to STD patients?	Yes ..... 1 No 2	
6.	Do you consider you need additional training on this disease?	Yes ..... 1 No 2	
7.	Are you providing care to TB patients	Yes ..... 1 No 2	
8.	Do you consider you need additional training on this disease?	Yes ..... 1 No 2	
9.	Are you providing care to AIDS patients	Yes ..... 1 No 2	
10.	Do you consider you need additional training on this disease?	Yes ..... 1 No 2	
11.	Are you providing care to Malaria patients	Yes ..... 1 No 2	
11.1.	Do you consider you need additional training on this disease?	Yes ..... 1 No 2	
12.	Will you provide care to STD patients if such necessity occurs?	Yes ..... 1 No 2	
13.	Is no, please specify why?	Yes ..... 1 No 2	
14.	Will you provide care to TB patients if such necessity occurs?	Yes ..... 1 No 2	
15	Is no, please specify why?	Yes ..... 1 No 2	
16.	Will you provide care to AIDS patients if such necessity occurs?	Yes ..... 1 No 2	
17	Is no, please specify why?	Yes ..... 1 No 2	
18.	Will you provide care to Malaria patients is such necessity occurs?	Yes ..... 1 No 2	
19.	Is no, please specify why?	Yes ..... 1 No 2	

20.	In your opinion is it safe to provide care to STD patients?	Yes ..... 1 No 2	
21.	In your opinion is it safe to provide care to TB patients?	Yes ..... 1 No 2	
22.	In your opinion is it safe to provide care to AIDS patients?	Yes ..... 1 No 2	
23.	In your opinion is it safe to provide care to Malaria patients?	Yes ..... 1 No 2	

Services	**24.Are you providing following services to patients in this facility?**	**25.How many hours per week are you performing in this facility on the issues indicated below?**	**26.Have you got any training during last 2 years?**	**27. What was the duration of the training? Who was providing training? (please specify the organization, if there is more than one, specify all of them)**
a. General medical care (Therapy practice)	Yes……..1 No……2 **è** 26	Hours _____	Yes……..1 No……2 **è** 24b	Days_____ Organization_____ Days_____ Organization_____
b. Patronage of newborns	Yes……..1 No……2 **è** 26	Hours _____	Yes……..1 No……2 **è** 24c	Days_____ Organization_____ Days_____ Organization_____
c. ANC supervision	Yes……..1 No……2 **è** 26	Hours _____	Yes……..1 No……2 **è** 24d	Days_____ Organization_____ Days_____ Organization_____
d. Family planning	Yes……..1 No……2 **è** 26	Hours _____	Yes……..1 No……2 **è** 24e	Days_____ Organization_____ Days_____ Organization_____
e. STD counseling	Yes……..1 No……2 **è** 26	Hours _____	Yes……..1 No……2 **è** 24f	Days_____ Organization_____ Days_____ Organization_____
f. HIV/AIDS counseling	Yes……..1 No……2 **è** 26	Hours _____	Yes……..1 No……2 **è** 24g	Days_____ Organization_____ Days_____ Organization_____
g. TB program	Yes……..1 No……2 **è** 26	Hours _____	Yes……..1 No……2 **è** 24h	Days_____ Organization_____ Days_____ Organization_____

h. Malaria program	Yes……1 No……2 **è** 26	Hours _____	Yes……1 No……2 **è** 24i	Days_____ Organization_____ Days_____ Organization_____
i. Are you involved in Administration and Management issues?	Yes……1 No……2 **è** 26	Hours _____	yes……1 No……2 **è** 24j	Days_____ Organization_____ Days_____ Organization_____
j. Outreach	Yes……1 No……2 **è** 26	Hours _____		
k. Other services	Yes……1 No……2 **è** 26	Hours _____		
	Total hours worked	Total hours_____		

28.	Are you willing to participate in trainings on HIV/AIDS, TB and Malaria?	**HIV/AIDS** Yes ……1 No ……2 **TB** Yes ……1 No ……2 **Malaria** Yes ……1 No ……2	
29.	Have you heard about GFATM project?	Yes……...1 No……..…….2	**è** 31
29.1	Are you participating in GFATM program and provide services to HIV/AIDS; TB and Malaria patients?	**HIV/AIDS** Yes ……1 No ……2 **TB** Yes ……1 No ……2 **Malaria** Yes ……1 No ……2	
29.2	Do you receive additional salary for participation in GFATM project?	**HIV/AIDS** Yes ……1 No ……2 **TB** Yes ……1 No ……2 **Malaria** Yes ……1 No ……2	
30	Are you willing to participate in GFATM program and provide services to HIV/AIDS; TB and Malaria patients?	**HIV/AIDS** Yes ……1 No ……2 (If no why?) _____ **TB** Yes ……1 No ……2 (If no why?) _____ **Malaria** Yes ……1	

		No ……..2 (If no why?) _____	
Section 2. Supervision			
No.	**Questions**	**Answers**	**Go to**
31.	During last 6 month how many supervisory visits were conducted in this facility?	Internal visits No. of visits _____ None_____00 External visits No. of visits _____ None_____00	
32.	Was it internal or external supervisor's visits?	Internal…….....1 External……..2 Both……...3	
33.	Who has conducted those visits? (Please specify the organization, structure for internal and external visits)	Internal visit 1. _____ 2. _____ 3. _____ External visit 4. _____ 5. _____ 6. _____	

Section 3. Motivation and satisfaction

I want you to answer some questions. I'll be repeating possible answers and try to scale each answer by 5 point system

No	**Question**	**Strongly Agree 1** **Agree 2** **Do not know 3** **Disagree 4** **Strongly disagree 5**
Motivation for working		
34.	I'm proud to work in this facility	1 2 3 4 5
35.	This facility have very good reputation	1 2 3 4 5
36.	GFATM will have positive impact on providers motivation	1 2 3 4 5
Remuneration		
37.	My present remuneration is according my knowledge, experience and capacity	1 2 3 4 5
38.	My salary covers my essential needs (nutrition, transportation, lodging)	1 2 3 4 5
39.	Per diems provided for outreach is enough?	1 2 3 4 5
Efficiency		
40.	I'm confident in my capacity to work efficiently	1 2 3 4 5
41.	I'm supervising all activities of this facility	1 2 3 4 5

42.	I've gained knowledge and skills in this facility which has enriched my experience	1 2 3 4 5
Stock		
43.	I've all needed equipment and supply to do my job	1 2 3 4 5
44.	Facility is providing all necessary supplies	1 2 3 4 5
45.	There is recourse shortage in the facility, which prevents me from doing high quality job.	1 2 3 4 5
Responsibilities		
46.	My performance is of high quality	1 2 3 4 5
47.	I'm responsible and very accurate person	1 2 3 4 5
48.	Quality of your performance is greatly affecting the health of the population	1 2 3 4 5
Following questions aims to find out if you are satisfied with your job. Please rate your answers according 5 point scale. (1) Not satisfied; (5) Very satisfied		
Satisfaction		1 2 3 4 5
49.	Are you satisfied with your current job?	1 2 3 4 5
50.	Are supplies enough in the facility?	1 2 3 4 5
51.	Are you satisfied with skills and knowledge you gained in this facility?	1 2 3 4 5

Section 4. Provider Income

I want to ask you about you salary and any other income if you have, just to estimate if your personal income is enough

No.	Question	Answer	Go To
52.	Are you paying payroll taxes, what is the percent you are paying?	Monthly salary's % _____	
53.	Are you receiving any additional sums (bonus) for travel, nutrition, per diems?	Yes……..…..1 No…….……2	**è** 55
54.	What is the sum your are receiving monthly? (If the respondent can not specify sums separately please indicate the total sum in other)	Per diem for field work _____ Additional for transport_____ Additional for food _____ Other _____	
55.	Do you have any other source of income?	Yes……..…..1 No…….……2	Finish interview
56.	What is you additional income?	Yes No Privet consultations 1 2 In formal payments 1 2 Other _____ 1 2	
F11.	**Interview was finished**	Hour ☐☐ Minutes ☐☐	

	Comments of Interviewer

F12. Region

1. Tbilisi
2. Kakheti
3. Adjara
4. Samegrelo

For the interviewer! If the respondent named more than two facilities in question 27, use this additional Table.

Services	27.B what was the duration of training? Who has provided training? (Please specify the name of the organization, if there is few such organizations please list all of them)
a) General Medical Care	3. days_____ Organization_____ 4. days_____ Organization_____
b) Patronage of newborns	3. days_____ Organization_____ 4. days_____ Organization_____
c) ANC supervision	3. days_____ Organization_____ 4. days_____ Organization_____
d) Family planning	3. days_____ Organization_____ 4. days_____ Organization_____
e)STD counseling	3. days_____ Organization_____ 4. days_____ Organization_____
f) HIV/AIDS counseling	3. days_____ Organization_____ 4. days_____ Organization_____
g) TB program	3. days_____ Organization_____ 4. days_____ Organization_____
h) Malaria program	3. days_____ Organization_____ 4. days_____ Organization_____

i) Administration and management	3. days_____ Organization_____ 4. days_____ Organization_____
j) Other services	3. days_____ Organization_____ 4. days_____ Organization_____

Thanks a lot!

Annex 6 List of Strategic documents

- State program for HIV/AIDS Prevention;
- National Health Policy document for 1999 – 2010 developed in 1999;
- National health Strategic Plan approved in 1999;
- Main directions in Health, developed in February 2007;
- Poverty Reduction Strategy paper, 2003;
- National response Analysis, 2007;
- National Strategic Plan of Action on HIV/AIDS, approved in September 2002 and updated in May 2006;
- Tuberculosis control plan 2007-2011;
- Malaria control strategy 2005-2015;
- The Presidential Decree on "Establishment of Country Coordination Mechanism (CCM) to fight HIV/AIDS, TB and Malaria" passed in June 2003;
- MoLHSA decree on approval of Country Coordination Mechanism membership and charter for the projects of the Global Fund to Fight AIDS, TB and Malaria in Georgia, approved in February 2005;
- Millennium Development Goals for Georgia.

Annex 7 List of policy document regarding three focal diseases

HIV/AIDS Control

The Law on HIV/AIDS Prevention

Georgia was one of the first former Soviet republics that reacted to the HIV/AIDS epidemic and adopted a law on "HIV/AIDS Prevention". The Law was adopted in March 1995 and amended in March 2000. The amended law became functional in January 2001.

The Law defines responsibilities for all levels of government, delineates responsibilities of specialized institutions, as well as the general population and infected persons. The Law recognizes the rights of citizens such as: a) voluntary screening for HIV/AIDS; b) protection of HIV/AIDS infected persons by ensuring their personal freedom, respect, safety and equity; c) access to diagnosis and treatment of infected individuals; d) ensure the human rights of infected individuals for confidentiality, personal privacy, free decision making; e) equal protection for infected individuals and their family members; f) rights and responsibilities, as well as protection measures of medical providers.

As it was mentioned above, the law was amended in 2000. The reason was certain clauses concerning the mandatory testing for foreign citizens, as well as Georgian citizens returning from long term business trips. They were required to be tested upon arrival, or officially submit the certificate concerning their HIV/AIDS status. All those clauses have been revoked; testing remains mandatory only for blood donors and in case of organ transplantation.

Nevertheless, there are still some clauses, which need to be upgraded in accordance to international norms:

- ü According to the amended law, infected persons are required to inform medical providers concerning their status. Argument for leaving this provision is the existing economic situation in the country, meaning the shortage of medical supplies, especially disposables in the facilities;
- ü There is a list of occupations, for which HIV positive person can not be employed; this is explained by high probability of transmission.

There are some other weak points in the legislation. For instance, there is maximum financial support for HIV+ individuals (they receive an amount that is double minimum salary in Georgia), however this does not cover the expenses for regular check-ups, travel and other costs related to the condition. Thus it can be viewed as symbolic financial assistance showing commitment of Georgian Government.

The Law defines that diagnosis and treatment for the HIV/AIDS patients are free of charge, and are covered by the State financed health programs. These programs will be described in detail below, but it has to be mentioned that currently planned reforms by the MoLHSA of Georgia are likely to abolish the majority of state funded programs, or their financing will be reduced.

For persons leaving outside the capital city, the Law provides for free of charge travel four times per year from their residence place to the capital city for a regular check-up and drug supplies. These costs should be covered by local budgets. This provision remains a mere declaration. Local Governments are not budgeting this costs, which can be understandable because in rural areas people usually try to keep their status confidentially, thus the local authorities may not be informed about cases at all.

The overall legislation has other important shortcomings. As it was described in previous section, the main route of HIV transmission in Georgia is intravenous drug use. In general there is an understanding of what has to be done and how, but until now drug abuse is considered as a criminal act by the Georgian legislation. Even as the Law ensures free of charge testing for high risk group representatives, including IDUs, the majority of them are afraid to disclose their drug use, fearing the persecution from the police. This situation limits the effectiveness of this provision for prevention of transmission among IDUs.

Because of this legislation, the harm reduction programs like needle or syringe exchange – which are effective in many countries around the globe, are implemented at very small scale in Georgia. NGOs or any other facilities that are providing such services, have to inform in advance the Ministry of Interior about their activities and clients. This raises concerns about privacy and safety.

Another important issue is the liberalization of the legislation concerning commercial sex. The country has failed to establish an environment in which it will be possible to ensure the effective prevention and testing measures in this group.

Overall it has to be underlined, that the existing Law on HIV/AIDS Prevention contains number of clauses which are not and were not implemented in practice. To our knowledge, at the time of the survey the team of local experts is working on a new, updated version of the law.

National Health Policy and National Strategic Plan – 1999 - 2010

The National Health Policy Document (NHPD), - a framework strategic document for the health sector in Georgia, - defines HIV/AIDS control and prevention as one of the priority areas for public health in Georgia in paragraph 2.7:

"Health and Healthy Lifestyle Promotion prioritizes prevention of HIV/AIDS/STD through improvement of the case detection and public awareness (information-education)."

The National Health Strategic Plan, which serves as an implementation and monitoring plan for the National Health Policy, proposes a number of strategies to achieve HIV/AIDS/STI goals and objectives of the NHPD. It also contains the cost forecasts for implementation of these strategies.

Combating TB epidemic in Georgia is one of the declared priorities in NHPD. The TB specific targets and strategies in the NHP are as following:

Target

To Reduce morbidity to 50–60 per 100 000 population by 2005, caused by multiresistant TB

Strategy
Implement diagnostic, curative and preventive measures offered by modern anti-TB strategy.

The Strategic Health Plan for Georgia 1999-2010 contains concrete measures, activities, indicators and cost estimates for pursuing the strategies and achieving the targets outlined in the NHPD. It is noteworthy that the strategic health plan calls for at least a 10% increase annually in financing of the NTP to cover a shortfall in the medical aspects of the program in order to eventually cover the cost of drugs, training, supervision, outreach services, equipment rehabilitation that are not funded under current state programs for TB. These gaps are only partly met by short-term international programs.

Combating Malaria epidemic in Georgia is one of the declared priorities in NHPD. The Malaria specific targets and strategies in the NHP are following:

Target

The rate of prevalence of malaria must be less than 5 per 100 000 population and lethality caused by malaria should not be registered

Strategy

- Improve epidemiological surveillance
- Enforcement of activities against carriers of the disease
- Improve the qualification of staff
- Create a stock of medications and insecticides"

The main goals, objectives and activities of the NMCP appear to be adequately reflected in this strategic plan. It is noteworthy that the strategic health plan calls for at least 5% increase annually in financing of the NMCP.

It has to be mentioned that both documents for the moment are outdated; they have to be updated in accordance with ongoing changes in health care system of Georgia. One of the strategic documents developed after the "Rose revolution", outlining the main priorities and directions of the health system in country is "Main Directions in State Policy for Health Care System".

The Main Directions in State Policy for Health Care System

The Main Directions in State Policy for Health Care System which was developed in February 2007 outlines the future steps of the GoG in improving the health status of Georgian population. It is not as explicit and structured as the National Health Policy document was, and is not talking separately about the actions towards the management of the situation in regards with HIV/AIDS. The wording is as follows:" The aim of the Health Care system is to improve the health status of the population, meaning an increase of life expectancy and quality of life, a decrease the burden of communicable and non-communicable diseases, an increase the immunization coverage, a decrease in maternal and child mortality…" This document outlines the targets set by the MDGs declaration, which Georgia joined in 2000.

The document outlines the overall proposed changes in the system, including the funding mechanisms (introduction of private insurance companies for the management of the State funded programs, the optimization of primary and secondary care sectors, the introduction of new payment methods for health providers (e.g. Disease Related Groups-DRGs). This document is not yet formally approved by the GoG, but is widely shared among the stakeholders.

Economic Development and Poverty Reduction National Program

A large burden has been placed on the economies of the countries most suffering from the global HIV/AIDS epidemic. It is understood that demographic characteristics of AIDS epidemic in Georgia and the trends in disease spread, if not curtailed, may create similar situation in the country. Hence, HIV/AIDS is recognized in this framework country strategic document as one of the important areas for interventions to achieve economic development and reduce poverty in Georgia. Poverty Reduction National Program was developed and approved by the GoG in 2003. This document is linked to the MDGs for Georgia: one out of the four Goals, which Georgia has committed to achieve, is to combat HIV/AIDS, Malaria and other diseases. The GoG recognizes the possible economic burden of HIV/AIDS, TB and malaria epidemic on the population and sets a goal to prevent the spread of these diseases.

Development of human capital via the improvement of health is one of four major priorities of the Economic Development and Poverty Reduction Program (EDPRP) of Georgia. The EDPRP recognizes the burden posed by the TB and strives to achieve a well-functioning NTP and tuberculosis control effort which will alleviate poverty by reducing mortality and work time lost through illness.

The EDPRP also recognizes the burden that may be posed by a wide scale malaria epidemic and strives to achieve a well-functioning NMCP and malaria control effort which will prevent poverty by reducing mortality and work time lost through illness. The NMCP will also benefit from successful implementation of other interventions planned under EDPRP, e.g. the improved management of public finances, clear definition of state responsibility in health care, improved access to basic health services and reform of primary care.

National Response Analysis in 2002, 2007

The National response analysis was conducted in 2002[9] as an initial starting point of the strategic planning process. Analysis has demonstrated that GoG has given high priority to HIV prevention activities, but with the available scarce resources, it was not possible to implement them fully at the National Level. It was assumed, that multi-sectoral plan of action, developed as a final step of strategic planning process, will improve the coordination between all stakeholders and help with resource mobilization. The following were identified as actions of first priority:

- Changes in existing legislation for the formation of a legal environment for work with high risk groups (harm reduction, needle exchange, methadone replacement therapy among IDUs, work with CSWs, MSM);
- HIV prevention activities have to be expanded beyond the health care system, meaning involvement of other government ministries and agencies like Ministry of Education as an example. This was envisaged as an effort to reach the younger age groups for promotion of healthy life style and safe sex practices;
- Improvement of quality of public awareness campaigns concerning HIV/AIDS prevention, including the resource mobilization for such activities;
- Expanding involvement of both national and international NGOs in HIV/AIDS prevention activities, especially at the regional level.

[9] Analysis of the National Response to HIV/AIDS in Georgia, Joint United Nations Programme on HIV/AIDS United Nations Children's Fund (UNICEF), Infectious Diseases, AIDS and Clinical Immunology Research Center, June 2002

The next analysis of the National[10] Response is presented in the UN joint support plan to HIV/AIDS in Georgia for 2007 – 2008, developed by UN Theme group and UN country team in January 2007. The document acknowledges the fact that since 2003, the joint efforts of the Government, the Global Fund, civil society, UN agencies and other donors have led to a number of critical achievements. As indicated in the 2006 UNGASS Country report, the following are the key achievements:

- Universal Access to symptomatic and Antiretroviral (ARV) treatment for all HIV/AIDS positive persons (it has to be mentioned that 100% of registered cases who were identified as eligible for treatment were provided with free of charge treatment by the GFATM project);
- Development of National Strategy for the prevention of mother-to-child transmission (PMTCT) and ensuring universal access to PMTCT services for pregnant women;
- Increased access to safe blood services with enhanced capacities of the blood banking systems in Georgia, not including the conflict-affected regions;
- Establishment of baseline for HIV programming in two locations (Tbilisi and Batumi) through BSS surveys among CSWs and IDUs (conducted in the frames of USAID funded HIV/AIDS/STI prevention program, implemented by Save the Children);
- Targeted HIV prevention interventions developed for most-at-risk groups (IDUs, CSWs and MSM) in Tbilisi, Batumi, Kutaisi and Zugdidi;
- Expanded opportunities for HIV/AIDS prevention among young people through peer education and youth friendly services.

According to the analysis, the GoG has critically reviewed the implementation bottlenecks within the national HIV/AIDS responses and has set revised country-tailored targets for reaching as close as possible universal access to HIV/AIDS prevention, treatment, care and support services by 2010.

In 2006 the Georgian Government with UN support revised the HIV/AIDS National Strategic Plan according to the Universal Access Roadmap.

National Strategic Plan of Action on HIV/AIDS approved in September 2002[11] and updated in May, 2006[12]

The overall goal of the first NSPA was reducing the further spread of the HIV/AIDS epidemic in Georgia through the development and implementation of effective control and prevention interventions in the high priority areas identified by the HIV/AIDS situation and response analysis.

The following major activities were identified:

1. Advocacy for development of adequate legislative basis for implementation of effective prevention interventions targeted at vulnerable groups of the population;
2. HIV/AIDS Prevention among IDUs, including IDUs in the penitential system;
3. HIV/AIDS and STI prevention among CSWs, MSM and their partners;
4. HIV/AIDS prevention among youth;
5. Safety of blood and blood products;
6. Prevention of mother to child transmission (PMTCT) of HIV infection;

[10] UN Joint Support Plan to HIV/AIDS National Response in Georgia 2007 – 2008, UN Theme Group on HIV/AIDS in Georgia, UN Country Team, January 2007

[11] National Strategic Plan of Action for HIV/AIDS Prevention in Georgia, 2003-2007. Joint United Nations Programme on HIV/AIDS (UNAIDS) United Nations Children's Fund (UNICEF) Infectious Diseases, AIDS and Clinical Immunology Research Center (IDACIRC), September 2002

[12] National Strategic Plan towards Universal Access to HIV/AIDS Prevention, Treatment, care and Support in Georgia 2006 - 2010. May 2006 (Draft)

7. Care and support for people personally affected by HIV/AIDS, and
8. Prevention of HIV transmission within health care facilities.

NSPA has analyzed the existing resources as well as has identified the financial gap. This analysis was used as a basis when developing the 2nd round proposal for scaling up HIV/AIDS prevention activities in Georgia. This attempt was successful and Georgia was awarded a 12 million USD grant for five years.

The strategic plan was revised in 2006 in accordance with the Universal Access Roadmap. The 2006 – 2010 National Plan envisages a comprehensive evidence-based and sustainable approach to the national HIV/AIDS response for ensuring attainment of as close as possible universal access HIV/AIDS prevention, treatment, care and support services by end of 2010.

Furthermore the 2006-2010 plan focuses on attainment of the Three Ones strategy targets as well as the strategies under the five year UNICEF and UNAIDS co-sponsored campaign "*Unite Children. Unite Against AIDS*."

The revised strategic plan was used as a base when developing the GFATM Round 6 proposal, which was approved and country will get additional resources for achieving outcome targets for each of following strategic areas:

1. HIV/AIDS surveillance;
2. Prevention;
3. Treatment, care and support;
4. National Commitment.

The outcome targets and corresponding indicators were identified by major stakeholders through a participatory process.

The total budget for above mentioned activities is estimated at 28,913,200 USD. This amount includes 8,256,600 USD already received from GFATM.

TB control

The government policy on TB prevention, control and treatment is defined by following major legal and policy documents:

- The National Program for TB Control and Prevention (NTP) introduced in 1995;
- Presidential Decree "On Additional Measures of TB Control in Georgia" issued in 1998;
- National Health Policy Document for 1999-2010 developed in 1999 by the Government of Georgia (discussed above);
- National Health Strategic Plan approved in 1999 (discussed above);
- Economic Development and Poverty Reduction Program, 2003 (discussed above) ;
- TB control Plan for Georgia 2007-2011[13] (Draft)

The National Program for TB Control and Prevention

In an attempt to curtail the TB epidemic, in 1995 the GoG initiated the National TB Program (NTP) with the support of the WHO and KfW/GTZ. The NTP was developed based on WHO recommendations and guidelines that significantly differed from the Soviet approach to managing TB patients. The NTP defines five year strategies for combating TB and sets framework for annual State Programs for TB control.

[13] Tuberculosis Control Plan for Georgia. National Center for Tuberculosis and Lung Diseases. Draft. March, 2006

Political commitment to TB control was re-declared in the **Presidential Decree Number 703** of October 8, 1998, *"On Additional Measures of TB Control in Georgia"*. The NTP has been made a priority and the DOTS strategy has been formally adopted countrywide.

The Management and Coordination Unit (CU) of the NTP is part of the National Center of Tuberculosis and Lung Diseases (NTBLD), a public entity supervised by the MoLHSA. It is financed by the central budget through allocation to the Social Insurance State United Fund (SISUF). The program is implemented by specialized TB dispensaries and hospitals that are contracted with SISUF.

As TB control in the penitentiary system was one of the major priorities, a separate public program for TB management in the penitentiary system was introduced in 1998 under the Framework of the NTP. In 1997 the Ministry of Internal Affairs of Georgia (MoIA) issued a decree regarding the implementation of the DOTS strategy in the penitentiary system.

The main goals and objectives of the NTP are following:

- identification of infectious cases;
- supporting patients through direct observation of treatment in the continuation phase;
- timely detection and quality treatment of cases;
- systematic monitoring of performance in case management;
- monitoring, evaluation and operations research;
- coordination and partnership development

TB control Plan for Georgia 2007-2011 (Draft)

This document was developed by the National Center for Tuberculosis and Lung Diseases in March 2006.

The purpose of the document is to streamline the plan of activities for TB control efforts for the period of 2007 – 2011. The overall goal set by document is to reduce the socioeconomic burden of TB on households and communities by decreasing mortality, morbidity and transmission of TB as well as preventing the development of drug resistance.

This is planned to be achieved through:

- Expansion and enhancement of a quality DOTS strategy;
- Development of the capacities for treatment of MDR-TB patients and the implementation of the DOTS – Plus strategy;
- Integration of TB control activities in ongoing health system reforms;
- Implementation of a framework for collaborative activities of TB/HIV co-infection control;
- Participation of the patients and the communities in TB control and in reduction of TB associated stigma;
- Support of TB related research.

The total budget for five years plan is estimated at 53,399,729 USD. This money is not received yet from any donors. This is estimated amount to implement the activities outlined in the action plan

Malaria Control

The government policy on Malaria prevention, control and treatment is defined by following major legal and policy documents:

- The National Malaria Control Program (NMCP) introduced in 2000;

- Presidential Decree Number 17 "On Strengthening the Malaria Control and Prevention Activities" in 2001;
- National Health Policy Document for 2000-2010 developed in 1999 by the Government of Georgia (discussed above);
- National Health Strategic Plan approved in 1999 (discussed above);
- Economic Development and Poverty Reduction Program, 2003 (discussed above);
- National Strategic Plan for Malaria Elimination in Georgia 2006 – 2015(Draft)

Within the transition period of fundamental political, social and economic turmoil in line with extreme scarcity of financial resources, the GoG expressed commitment towards the establishment of an effective malaria control system in the country. The National Malaria Control Programme (NMCP) has been adopted in 2000 within the scope of the Roll Back Malaria initiative. The NMCP has been developed and implemented in close collaboration with WHO Lesion Office and WHO/EURO. The strong political commitment has been re-declared through issuance of the Presidential Decree Number 17/2001 "On Strengthening the Malaria Control and Prevention Activities" in the country. The government contribution to the NMCP comprised 276,000 GEL (US $ 138,000) in 2000, with 400,000 GEL (US $ 185,000) allocated for the FY 2001 and 2002. The total budget allocated by the Government for NMCP in 2003 comprises 429,000 GEL (approx. 225,000 US $ as per the current ex-change rates), the funding expected to be maintained throughout next 3 years. The increase of the state budget allocations from US $ 138,000 to US $ 225,000 demonstrates the governmental commitment for strengthening the NMCP performance. WHO LO and the Regional Office for Europe are currently the main partners in supporting the RBM initiative in Georgia. WHO/EURO has provided US$ 60,000 in 2000, US$ 44,000 in 2001 and US$ 30,000 in 2002. Funds have been used to support the malaria program, including the procurement of anti-malaria drugs, laboratory equipment, spraying equipment and insecticides, as well as the capacity building activities for the national program staff. USAID Caucasus office also has provided valuable assistance to the NMCP, through provision of IT equipment and renovation of the NCDC premises, including the office of the National Malaria Control Program.

Since 2000 Georgia has been actively involved in coordination and consultation meetings with Roll Back Malaria partners. However within the country, effective partnership with major donors has not been yet established. At present resources invested for malaria control by the Government and external donors are limited and the country is in urgent need of additional external assistance to effectively cope with the malaria problem. The increase in malaria incidence in Georgia gives rise to the danger that transmission may become much more serious unless a thorough analysis of needs and priorities are carried out and effective proactive prevention interventions taken.

National Strategic Plan for Malaria Elimination in Georgia 2006 – 2015(Draft)[14]

The overall goal set by the document is the elimination of malaria cases by 2015. The list of targets below details how the country is planning to achieve the goal:

- Reduce Morbidity;
- Use the experience and achievements of Roll Back Malaria and th Global Fund;
- Ensure political support at the national level to be able to achieve ambitious targets;
- Availability of new technologies and supplies to eliminate malaria in a regional context;
- Stop the transmission and eliminate cases, as it was done in the past.

[14] National Strategic Plan for Malaria Elimination in Georgia. National Center for Disease Control. (Draft). 2006

The plan is very ambitious, but is based on past experience of malaria elimination in Georgia. The malaria component for the Round 6 GFATM proposal was developed based on the above mentioned document and it is expected that implementation will start this year.

It has to be underlined that proposals for all three components of the GFATM Round 6 proposal were developed based on strategic documents described above. There is a consensus concerning the content of the documents at the National level, but the latest three documents are still drafts; the finalized document is not yet available.

The Presidential Decree on "Establishment of Country Coordination Mechanism (CCM) to Fight HIV/AIDS, TB and Malaria passed in June 2003

Prior to submission of the the Round 2 GFATM proposal, the Government Commission on HIV/AIDS and other Socially Dangerous Diseases was transformed into a Country Coordination Mechanism in accordance with GFATM requirements. This transformation mainly entailed inclusion of NGOs and international development partner representatives in the Commission. According to stakeholders interviews conducted during the baseline survey, before the initiation of the strategic planning process in 2001, meetings of the Commission were formal, irregular and not effective. Formation and work of the sectoral task forces in close collaboration with international organisations and representatives of civil society has increased the effectiveness of the Commission and logically led to the formation of the CCM, where development partners and NGOs were officially represented.

The number of members of the CCM increased from 19 to 39 by May 2004. Up to the end of 2004, the number of members had further increased up to 46. The widened representation on the CCM has been assessed as a positive development from a participatory point of view; however, also it has negatively affected the efficiency of CCM. Membership was too wide and recognized to be less effective. At the end of year 2004 it was decided to reduce the number of members to 30. Ministries were asked to reduce their presence by leaving only one representative (the First deputy Minister), while NGOs were advised to introduce a rotation principle and elect their representative annually. Representatives of PLWHA are permanently represented on the CCM.

Report of stakeholders interviews provides much more in-depth information concerning the CCM formation and effectiveness, but it has to be mentioned that the majority of respondents had underlined the fact that the CCM became effective after appointing Georgia's First Lady Sandra Elizabeth Roloefs as its Chair.

In the SWEF[15] baseline report it was underlined that the CCM role in priority setting and proposal development for three focal diseases has been limited. Due to time limitations in the submission period and language limitations, not all members were able to review the proposal and express their opinion. Thus not all of them were familiar with the content of the proposals. At that time contribution from ministries other than MoLHSA was negligible. The baseline report also revealed potential for conflict of interest as most of prospective grant implementators were members of CCM: e.g. the majority of NGOs working in the field of HIV/AIDS (there are no NGOs working in field of TB and malaria), were CCM members. One of the CCM's major functions is to monitor the GFATM project implementations and the ones who were implementing, were supposed to evaluate their own projects. It is assumed that this was another reason for the introduction of the rotation principle for membership among NGOs.

[15] System wide affects Global Fund on Georgia's Health care Systems. Curatio International Foundation, 2005. Available at: www.curatiofoundation.org;

For the time of the follow-up study, only one NGO implementing the GFATM project was presented on the CCM.

Beside the changes in composition and the appointment of the new Chair, some other structural changes were introduced. CCM secretariat was established that is represented by executive secretary and 2 technical consultants (in TB and HIV/AIDS components). USAID provided financial support during the first 6 months for initial start-up activities of the CCM secretariat (and the salary of the executive secretary and equipment was covered by USAID). Currently, all expenses related to the CCM secretariat functioning are covered by the GFATM. The CCM charter and bylaws were approved by *MoLHSA Decree on approval of the Country Coordination Membership and Charter for the projects of the Global Fund to Fight AIDS, TB and Malaria in Georgia issued in February 2005*. This decree streamlines responsibilities of CCM members, puts in place the structure, defines the frequency of the meetings, as well as functions and responsibilities of CCM secretariat.

For the moment, the CCM serves as a coordination mechanism not only for GFATM projects, but overall activities conducted in the field of HIV/AIDS and TB and appears to be effective in achieving its aims, according to the respondents of tracking study. Researchers were not able to document the opposite opinion.

Millennium Development Goals'

One of the MDGs to which Georgia is signatory is Goal 6: Combat HIV/AIDS, Malaria and other diseases.

There are two targets identified:
Target 12: Have halted by 2015 and begun to reverse the spread of HIV/AIDS;
Target 13: Have halted by 2015 and begun to reverse the incidence of Malaria and other major diseases.

According to the UNDP evaluation report on the MDGs[16] in Georgia, published in 2004, active efforts by the government towards effective prevention and control of the spread of communicable and socially dangerous diseases were reinforced by the Reform and Development Programme of the Government for 2004-2009.

The National Strategic Plan of Action on HIV/AIDS currently supported through the GFATM project, remains a government priority. It envisages changes in the legislative framework, preventive measures in different risk groups (IDUs, CSWs), prevention of mother-to-child transition of HIV infection, treatment and care of HIV/AIDS patients, and strengthening of the safe blood programme. The active involvement of NGOs enhances government efforts in this area.

Current legislation makes it difficult to conduct preventive intervention among HIV/AIDS high-risk groups. Low levels of state funding and inter-sector coordination are serious impediments for effective interventions. It is also important to improve the information base to enable comparison and analysis of baseline and future data.

Despite the eight years of operation of the state anti-TB programme disease control is still imperfect. The integration of activities on TB control has yet to be achieved due to the lack of coordination on the primary health care level. Outreach services need to be developed. All these contribute to low levels of disease detection (50% against the international minimum requirement of 70%) and comparatively high level of abandoned treatment (14% against the international requirement of less than 10%). After successful expansion of the DOTS strategy, Georgia should move to the implementation of the DOTS-Plus strategy that implies treatment of drug-resistant forms of the disease.

[16] Millennium Development Goals in Georgia. Evaluation Report. UNDP, 2004

Annex 8 List of organizations assessed through NGO assessment tool

NAME OF THE ORGANIZATION	LEGAL STATUS
1. Center for Information and Counseling on Reproductive Health "Tanadgoma"	Association
2. The Union of Victims of the Conflict in Abkhazia "Tanadgoma"	NGO
3. "Children's Federation"	Legal entity of public law
4. International Youth Network for Peace and Cooperation "Juvenco"	Union
5. HIV/AIDS patients support Foundation	NGO
6. Psycho-Social Information and Counseling Centre "Akhali Gza"	Union
7. The Centre for Medical, Socio-Economic and Cultural issues "Uranti"	Union
8. "Central Institute for Retraining Teachers and Attestation"	State LTD
9. "Georgian Association of Obstetricians and Gynecologists"	Association
10. "Open Society – Georgia Foundation" - OSGF	Foundation

Annex 9 List of PPP's formed for GFATM tendering process

Prime contractors	Sub-contractors
1. Center for Information and Counseling on Reproductive Health "Tanadgoma"	1.National AIDS center; 2. National STI Institute
2. Children's Federation	1. International Youth Network for Peace and Cooperation "Juvenco" 2. Center for Information and Counseling on Reproductive Health "Tanadgoma" 3. National AIDS center; 4. "Central Institute for Retraining Teachers and Attestation"
3. "Open Society – Georgia Foundation" - OSGF	1. Psycho-Social Information and Counseling Centre "Akhali Gza" 2. National Institute of Drug addiction
4. National Institute of Drug addiction	1. The Centre for Medical, Socio-Economic and Cultural issues "Uranti"
5. National AIDS center;	1. HIV/AIDS patients support Foundation
6."Georgian Association of Obstetricians and Gynecologists"	1. National AIDS center;